

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

N000000	<p>This visit was for a home health state relicensure survey.</p> <p>Survey Dates: February 4, 6, 7, and 10, 2013.</p> <p>Facility Number: 06648.</p> <p>Surveyor: Janet Brandt, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 160 Home Health Aide Only: 0 Personal Care Only: 0 Total: 160</p> <p>Sample: RR w/HV: 2 RR w/o HV: 4 Total: 6</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN  February 18, 2014</p>	N000000		
---------	--	---------	--	--

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

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, observation, and interview, the agency failed to ensure that treatments were provided as ordered on the plan of care for 5 of 6 records reviewed (#1, #2, #3, #5, #6) with the potential to affect all the agency patients.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 7/27/11, included a plan of care for the certification period 11/13/13 to 1/11/14 with orders for the skilled nurse to visit 1-2 times a week for 9 weeks to instruct patient / primary care giver regarding 1) COPD: signs/symptoms, predisposing factors and management, energy conservation techniques, effective</p>	N000522	<p>1.) The Executive Director/DON has inserviced nursing staff that medical care shall follow a written medical plan of care established and periodically reviewed and developed with consultation with physician and with home health agency staff. It includes all services to be provided and covers all pertinent diagnoses. medical plan of care will be consistently reviewed to ensure that patient needs are met and will be updated as necessary Medical plan of care should be individualized to meet specific identified needs. Documentation in the patient record that reflects the plan of care is reviewed for appropriateness to see if care being provided is still needed.; effectiveness to evaluate patient outcomes. To determine if all needs are being provided and</p>	02/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>coughing, pursed lip or diaphragmatic breathing techniques; 2) Oxygen therapy: 2-3 Liters per nasal cannula as needed for shortness of breath, safety precautions, signs and symptoms of oxygen toxicity; 3) Diabetes Mellitus: disease process, foot assessments, signs/symptoms of hypo/hyperglycemia, glucometer use, diabetic medications, diet; 4) Edema: Measures to detect and alleviate edema; 5) Cardiac: Signs/Symptoms of heart attack; and 6)UTI: Signs/symptoms to report to physician, preventative measures and therapeutic effectiveness.</p> <p>a) The record failed to evidence a skilled nurse visit was made week 6 (12/15/13-12/21/13) or week 7 (12/22/13-12/27/13).</p> <p>b) Skilled nursing visits dated 11/13/13, 11/18/13, 11/25/13, 12/2/13, 12/5/13, and 12/9/13 failed to evidence instruction completed for 1) COPD, signs/symptoms, predisposing factors and management, energy conservation techniques, effective coughing, pursed lip or diaphragmatic breathing techniques; 2) Oxygen Therapy: 2-3 Liters per nasal cannula as needed for shortness of breath, safety precautions, signs and symptoms of oxygen toxicity; 3) Diabetes Mellitus:</p>		<p>change in patient's condition. Ensure that treatments were provided as ordered in the plan of care. Clinical documentation should reflect the plan of care. 15% of all clinical records will be audited and reviewed quarterly to ensure that medical plan of care will be reviewed to make sure that patient's needs are met and treatments are provided. The Executive director/DON will be overall responsible for monitoring this corrective action to ensure this deficiency is corrected and will not reoccur. Formulated Quarterly medical plan of care review and quarterly skilled visit assessment and documentation review. a.) The Executive director/DON provided to the surveyor what she asked for last two certifications week 4 and week 6 only. Attached: week 7b.) The Executive director/DON has inserviced skilled staff that medical care shall follow a written medical plan of care established and periodically reviewed and developed with consultation with physician and with home health agency staff. It includes all services to be provided and covers all patient diagnoses. Plan of care will be consistently reviewed to ensure that patient's needs are met and will be updated as necessary. Medical plan of care should be individualized to meet specific identified needs. Documentation</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>disease process, foot assessments, signs/symptoms of hypo/hyper glycemia, glucometer use, diabetic medications, diet; 4) Edema: Measures to detect and alleviate edema; and 5) Cardiac: Signs/Symptoms of heart attack.</p> <p>c) Skilled nursing documentation for visits on 11/13/13, 11/18/13, 11/25/13, 12/2/13, 12/5/13, and 12/9/13 indicated the nurse, Employee L, performed wound care by cleansing a coccyx wound with Normal Saline, applying Santyl, and covering with a tegaderm. The plan of care failed to evidence an order for wound care.</p> <p>2. Clinical record #2 included a plan of care for the certification period 11/23/13-1/21/14 with orders for the skilled nurse to visit 1-2 times weekly for 8 weeks, the home health aide to visit 1 time week 1 then 2 times weekly for 8 weeks, and physical therapy to visit 2 times weekly for 4 weeks. The skilled nurse was to instruct the patient on 1) Pain: Pain management, measures to prevent pain, signs/symptoms of arthritis, Taking pain medication before pain becomes severe to achieve better pain control, non-pharmacological pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs; 2)</p>		<p>in the patient's records that reflects the plan of care is reviewed for appropriateness to see if care being provided is still needed, effectiveness to evaluate patient outcomes. To determine if all needed care is being provided and change in patient condition as well. Ensure that treatments are provided as ordered in the plan of care. Clinical documentation should reflect plan of care. 15% of all clinical records will be audited and reviewed quarterly to ensure that medical plan of care will be reviewed to make sure that patient needs are met and treatments are provided. The Executive director/DON will be overall responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.c.) Plan of care provided to the surveyor with treatment on the wound.attached: plan of care, medication profile, and medication reconciliation2.) The Executive director/DON inserviced the staff thst medical care shall follow a written plan of care established and periodically reviewed and developed with consultation with physician and home health agency staff. It includes all services provided and covers all pertinent diagnoses. Plan of care will be consistently reviewed to ensure that patient needs are met and will be updated as necessary. Medical plan of care will be individualized</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Arthritis: Lumbar arthritis-signs/symptoms to refer to medical doctor or skilled nursing, prevention of complications and compliance to pain medications; 3) COPD: Breathing techniques (pursed lip breathing, diaphragmatic breathing techniques), energy conserving measures, effective coughing, the nature of COPD, signs/symptoms, predisposing factors; 4) Cardiac: Measures to recognize cardiac dysfunction and relieve complications, signs/symptoms of heart attack, when to call 911, signs/symptoms of hyper/hypotension, emergency measures to take, energy conservation techniques, measures to minimize effects of orthostatic hypotension; 5) Edema: Measures to detect and alleviate edema; 6) Chest Pain: Nitroglycerin dose, when to call 911; 7) Bladder retraining program: timed voiding; 8) Urinary Tract Infection: Signs/symptoms; 9) Diet; 10) Depression: Disease process/management of depression, coping skills; 11) Exercise: Range of Motion exercises, body alignment techniques, muscle strengthening exercises to increase energy; 12) Safety: proper footwear when ambulating, proper lighting; 13) Medications: Teach related to dose, indications, side effects, interactions, precautions for high risk</p>		<p>to meet specific identified needs. Documentaion in the patient record that reflects the plan of care is reviewed for appropriateness if care being provided is still needed, effectiveness to evaluate patient outcomes. To determine if all needed are is being provided and change in patient's condition. To ensure that treatments were provided as ordered in the plan of care. Clinical documentation should reflect plan of care. 15% of all clinical records will be reviewed and audited quarterly to ensure that medical plan of care will reviewed that patient needs are met and treatments are provided. The Executive director/DON will be overall responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recurr.a.) skilled nursing, home health aide, and physical therapy week 1 was provided to the surveyor except skilled nursing recert oasis dated 11/22/13 and physical therapy re-evaluation dated 11/21/13. See attached.b.) The Executive director/DON inserviced the staff that medical care shall follow a written medical plan of care established and periodically reviewed and developed with consultation with physician and home health agency staff. It includes all services to be provided and covers all pertinent diagnoses. Medical plan of care</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>medications such as hyperglycemics, anticoagulant, sedative hypnotics, antiarrhythmics, antineoplastics, skeletal muscle relaxants, signs/symptoms of ineffective drug therapy to report to skilled nurse or physician.</p> <p>a) The record failed to evidence any visits were made by the skilled nurse, home health aide of physical therapist during week 1.</p> <p>b) Skilled nursing visits dated 11/26/13, 11/30/13, 12/05/13, 12/13/13, 12/18/13, 12/28/13, 1/4/14, 1/10/14, and 1/17/14 failed to evidence instruction was completed for 1) Pain: Pain management, signs/symptoms of arthritis, non-pharmacological pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs; 2) Arthritis: Lumbar arthritis-signs/symptoms to refer to medical doctor or skilled nursing, prevention of complications; 3) COPD: Breathing techniques (pursed lip breathing, diaphragmatic breathing techniques), energy conserving measures, effective coughing, the nature of COPD, signs/symptoms, predisposing factors; 4) Cardiac: Measures to recognize cardiac dysfunction and relieve complications, signs/symptoms</p>		<p>will be consistently reviewed to ensure that patient needs are met and will be updated as necessary. Medical plan of care should be individualized to meet specific identified needs. Documentation in the patient record that refelects the plan of care is reviewed for appropriateness to see if care being provided is still needed, effectiveness to evaluate patient outcomes, to determine if all needed care is being provided and change in patient condition. Ensures that treatments were provided as ordered in the plan of care. Clinical documentation should reflect the plan of care. 15% of all clinical records will be reviewed and audited quarterly to ensure that plan of care will be reviewed and patient needs are met and treatments are provided. The Executive director/DON will responsible for monitoring this corrective action to ensure this defeciency is corrected and will not recur. 3.) The Executive director/DON has inserviced the staff that medical care shall follow a written plan of care established and periodically reviewed and developed with consultation with the physician and with home health agency staff. It includes all services to be provided and covers all pertinent diagnoses. madical plan of care will be consistently reviewed to ensure that patient needs are met and will be updated as necessary. Medical plan of care should be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>of heart attack, when to call 911, signs/symptoms of hyper/hypotension, emergency measures to take, energy conservation techniques, measures to minimize effects of orthostatic hypotension; 5) Bladder retraining program: timed voiding; 6) Urinary Tract Infection: Signs/symptoms; 7) Diet; 8) Depression: Disease process/management of depression, coping skills; 9) Exercise: Range of Motion exercises, body alignment techniques, muscle strengthening exercises to increase energy; and 10) Medications: Teach to dose, indications, side effects, interactions, precautions for high risk medications such as hyperglycemics, anticoagulant, sedative hypnotics, antiarrhythmics, antineoplastics, skeletal muscle relaxants, signs/symptoms of ineffective drug therapy to report to skilled nurse or physician.</p> <p>3. Clinical record #3, start of care (SOC) 02/23/13, included a plan of care for the certification period 12/20/13-2/17/14 with orders for skilled nurse 1-2 times weekly for 8 weeks and the home health aide to visit 2 times weekly for 8 weeks. The skilled nurse was to complete an assessment for Pain; Skin; Respiratory system; Asses weight log; Assess for dietary compliance;</p>		<p>individualized to meet specific identified needs. Documentation in the patient record that reflects the plan of care is reviewed for appropriateness to see if care being provided is still needed, effectiveness to evaluate patient outcomes, to determine if all needed care is being provided as ordered on the plan of care, clinical documentation should reflect plan of care. 15% of all clinical records will be audited and reviewed quarterly to ensure that patient needs are met and treatments are provided. The Executive director/DON will be overall responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur. a.) Skilled nurse visit week 1 given to the surveyor except oasis recertification visit dated 12/17/13. Home health aided visit given to the surveyor dates 12/23/13 and 12/27/13. See attached. b.) Physician telephone orders given to the surveyor. Physical therapy to evaluate dated 01/24/14. Telephone order with physical therapy frequency dated 01/27/14. The surveyor only asked for skilled nurse and home health aide clinical documentation. Physical therapy not included in the plan of care because it was started in the middle of the episode. See attached. c.) The Executive director/DON has inserviced all skilled nurses on the importance</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cardiac: for hypertension/hypotension; Neurological: changes in neuro status, changes in communication; Assess for compliance with home exercise program; Assess for patient/caregiver ability to correctly fill patient's medication box each visit, patient/caregiver ability to verbalize understanding of the indication for each medication, patient/caregiver ability to open medications, patient/caregiver's ability to give an injectable medication every visit; and to instruct on 1) Safety measures related poor vision; Importance of influenza and pneumococcal vaccines; 2) Non-pharmacological pain relief measures, including relaxation techniques, massage, stretching, hot/cold packs, Pain management related to predisposing factors, precautionary measures; 3) Nature of COPD: signs/symptoms, predisposing factors energy conservation techniques effective coughing, pursed lip breathing; 4) Diabetic management: disease process, signs/symptoms of hypo/hyper glycemia, glucometer use and care, giving diabetic medications, diabetic foot care , appropriate nail care, hygiene finger stick, prescribed diet and nutrition, insulin therapy preparation, its purpose, onset, aseptic technique, injection site rotation, complications and		of completing all the assessments and teachings during skilled visits.15% of all clinical records will be audited to check if all skilled assessments and teachings are completed by the home health agency staff.The Executive director/DON will be overall responsible for monitoring this corrective action to ensure this deficiency is corrected and will not reccur.d.) The Executive director/DON has inserviced all skilled nurses on the importance of completing all the assessments and teachings during skilled visit.15% of all clinical records will be audited to check if the skilled assessments and teachings are completed by home health agency staff.The Executive director/DON will be overall responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.e.) The Executive director/DON has inserviced all skilled nurses on completing all assessments, observations, and documentation and notifying the attending physician for any change in patient condition that warrants immediate attention.15% of all clinical records will be audited to check if the skilled assessments and observations of by the skilled nurse is properly documented and reported.The Executive director/DON will be overall responsible for monitoring this corrective action to ensure this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>local allergic reactions; 5) Measures to detect and relieve edema; 6) Signs/Symptoms of heart attack, 7) Exercise within cardiac limitations, exercise regimen, complications, risk factors; 8) Signs / Symptoms of coronary artery disease, prevention, importance of diet and exercise; 9) Bladder retraining program, including timed voiding; 10) Signs/Symptoms of urinary tract infection: including pain, foul odor, cloudy or blood tinged urine; 11) Activity to alleviate constipation; 12) Benign prostatic hypertrophy, therapeutic management; 13)Hypothyroidism: signs/symptoms; 14) Anemia: Causes, Signs/symptoms; 15) Hypercholesterolemia: High cholesterol foods..</p> <p>a) The record failed to evidence any skilled nurse or home health aide visits during week 1.</p> <p>b) During a home visit on 2/7/14 at 10:00 AM, physical therapy was observed to be providing services. The record failed to evidence an order for physical therapy services.</p> <p>On 2/10/14 at 12 Noon, Employee A indicated there was no further chart documentation to offer for review.</p>		<p>deficiency is corrected and will not recur.1.) The Executive director/DON has inserviced all skilled nurses on the importance of proper assessments, documentations, observations, and reporting of any change in patient's condition that warrants immediate attention.15% of all clinical records will be audited to check if the skilled assessments and observations are properly documented and reported during skilled visit. The Executive director/DON will be overall responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.2.) The Executive director/DON has inserviced all skilled staffs that medical care shall follow a written medical plan of care established and reviewed for appropriateness and effectiveness and should be documented in the clinical record.15% of clinical record will be audited to check if plan of care is being followed according to the assessments, observations, and reporting to the physician any change in patient's condition that warrants immediate attention.The Executive director/DON will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will recur.3.) The Executive director/DON has inserviced all staff about the importance of thorough assessment of the patient, good clinical</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>c) Skilled nurse visit notes dated 2/4/14, 1/29/14, 1/21/14, 1/14/14, 1/8/14, 1/2/14, and 12/26/13 failed to evidence all the assessments had been completed.</p> <p>d) Skilled nurse visit notes dated 2/4/14-12/26/13 failed to evidence the SN completed teaching related to 1) Hypercholesterolemia, high cholesterol foods, management; 2) Anemia: Causes, signs, symptoms; 3) Hypothyroidism, signs/symptoms, management and treatment; 4) Benign Prostatic Hypertrophy: therapeutic management, manifestation of disease progression, or complications associated with the disease; 5) Bladder retraining program; 6) Coronary artery disease; 7) Diabetic management: glucometer care, hygiene finger stick, insulin therapy preparation, purpose, onset, injection site rotation, complications and local allergic reactions; 8) COPD: pursed lip breathing, energy conservation; 9) Constipation; and 10) Precautions of high risk medications such as hypoglycemics, anticoagulants/antiplatelet, sedative hypnotics, narcotics, antiarrhythmics, antineoplastics skeletal muscle relaxants. Medication side effects to report to physician.</p> <p>e) The medical record evidenced a</p>		<p>observations, and notifying the attending physician for any observations that warrants immediate attention.15% of the clinical record will be audited to check is assessments, observations during skilled visits are properly managed, communicated according to the plan of care.The Executive director/DON will be responsible to ensure this defieny is correted and will not recur.4.) The Executive director/DON has inserviced all skilled staff that medical care shall follow a written plan of care established and reviewed for appropriateness and effectiveness and to document in the clinical record.15% of clinical record will be audited to check if plan of care is being followed according to the assessments, observations, and teachings during skilled visit.The Executive director will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.5.) The Executive director/DON has inserviced all skilled staffs that medical care shall follow a written plan of care established and reviewed for appropriateness and effectiveness and to document in the clinical record.15% of the clinical records will be audited to check if the plan of care is being followed according to the assessments, observations, and teachings during skilled visit.The Executive director/DON will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>skilled nurse visit took place 12/26/13. Employee N documented, "Urine still cloudy and dark." No further assessment was documented by the nurse.</p> <p>1) The clinical record evidenced a skilled nurse visit with Employee N, registered nurse, on 1/2/14. The nurse documented the patient as having "cloudy yellow urine." No further assessment was documented by the nurse.</p> <p>2) The Plan of Care for the certification period 12/20/13-2/17/14 includes physician orders for the nurse to "obtain urinalysis and urine culture and sensitivity test as needed for signs/symptoms of UTI (urinary tract infection) to include pain, foul odor, cloudy or blood-tinged urine and fever." The record failed to evidence a culture and sensitivity test had been completed.</p> <p>3) On 1/14/14 at a physician visit, the patient was placed on an oral antibiotic for kidney infection</p> <p>4. Clinical record #5 included a plan of care for the certification period 10/25/13-12/23/13 with orders for the skilled nurse to visit 1-2 times weekly for 9 weeks and the home health aide to</p>		<p>responsible for monitoring corrective action to ensure that this deficiency is corrected and will not recur.6.) The Executive director/DON has inserviced all the skilled staffs that medical care shall follow a written plan of care established and reviewed for appropriateness and effectiveness and to document in the clinical record during skilled visit.15% of the clinical records will be audited quarterly to check if plan of care is being followed according to the assessments, observations, and teachings during skilled visit.The Executive director/DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.7.) The Executive director/DON has inserviced all the skilled staffs that medical care shall follow a written plan of care established and reviewed for appropriateness and effectiveness and to document in the clinical record during skilled visit.15% of clinical record will be audited quarterly to check if plan of care are being followed and reviewed to make sure patient needs are met.The Executive director/DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>visit 2 times a week for 8 weeks, then 1 time weekly for 1 week. The skilled nurse was to instruct the patient/primary caregiver regarding 1) Safety measures related poor vision; 2) Importance of influenza and pneumococcal vaccines; 3) Non-pharmacological pain relief measures, including relaxation techniques, massage, stretching, hot/cold packs, Pain management related to predisposing factors, precautionary measures; 4.) Nature of COPD: signs/symptoms, predisposing factors energy conservation techniques effective coughing, pursed lip breathing; 5) Diabetic management: disease process, signs/symptoms of hypo/hyper glycemia, glucometer use and care, giving diabetic medications, diabetic foot care , appropriate nail care, hygiene finger stick, prescribed diet and nutrition, insulin therapy preparation, its purpose, onset, aseptic technique, injection site rotation, complications and local allergic reactions; 6) Measures to detect and relieve edema; 7) Signs/Symptoms of heart attack; 8) Exercise within cardiac limitations, exercise regimen, complications, risk factors; 9) Signs / Symptoms of coronary artery disease, prevention, importance of diet and exercise; 10) Bladder retraining program, including timed voiding; Signs/Symptoms of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>urinary tract infection: including pain, foul odor, cloudy or blood tinged urine; 11) Activity to alleviate constipation; 12) Benign prostatic hypertrophy, therapeutic management; 13) Hypothyroidism: signs/symptoms; 14) Anemia: Causes, Signs/symptoms; 15) Hypercholesterolemia: High cholesterol foods.</p> <p>Skilled nurse visit notes dated 2/4/14-12/26/13 failed to evidence the Registered Nurse completed teaching related to 1) Hypercholesterolemia, high cholesterol foods, management; 2) Anemia: Causes, signs, symptoms; 3) Hypothyroidism, signs/symptoms, management and treatment; 4) Benign Prostatic Hypertrophy: therapeutic management, manifestation of disease progression, or complications associated with the disease; 5) Bladder retraining program; 6) Coronary artery disease; 7) Diabetic management: glucometer care, hygiene finger stick, insulin therapy preparation, purpose, onset, injection site rotation, complications and local allergic reactions; 8) COPD: pursed lip breathing, energy conservation.</p> <p>5. Clinical record #6 included a plan of care for the certification period 12/4/13-2/1/14 with orders for the skilled nurse to visit 1-2 times weekly</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for 9 weeks and the home health aide to visit 1-2 times a week for 9 weeks. The skilled nurse was to instruct the patient/primary caregiver regarding 1) Importance of influenza and pneumococcal vaccines; 2) Non-pharmacological pain relief measures, including relaxation techniques, massage, stretching, hot/cold packs, Pain management related to predisposing factors, precautionary measures; 3) Diet: Cardiac, diabetic diets instruction; 4) Diabetic management: disease process, signs/symptoms of hypo/hyper glycemia, glucometer use and care, giving diabetic medications, diabetic foot care , appropriate nail care, hygiene finger stick, prescribed diet and nutrition, insulin therapy preparation, its purpose, onset, aseptic technique, injection site rotation, complications and local allergic reactions; 5) Measures to detect and relieve edema; 6) Signs/Symptoms of heart attack; 7) Exercise within cardiac limitations, exercise regimen, complications, risk factors; 8) Signs / Symptoms of coronary artery disease, prevention, importance of diet and exercise; 9) Bladder/bowel incontinence: Care and management; 10) Signs/Symptoms of urinary tract infection: including pain, foul odor, cloudy or blood tinged urine;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>11) Cardiac dysfunction: Recognize and relieve complications; 12) Activity to alleviate constipation; 13) Nitroglycerine: when to take; 14) Medications: Side effects, medication reactions to report to physician or skilled nurse, precautions for high risk medications.</p> <p>Skilled nurse visit notes dated 12/4/13-2/1/14 failed to evidence the skilled nurse completed teaching related to 1) Importance of influenza and pneumococcal vaccines; 2) Non-pharmacological pain relief measures, including relaxation techniques, massage, stretching, hot/cold packs, Pain management related to predisposing factors, precautionary measures; 3) Diabetic management: disease process, signs/symptoms of hypo/hyper glycemia, glucometer use and care, giving diabetic medications, diabetic foot care , appropriate nail care, hygiene, finger stick, prescribed diet and nutrition, insulin therapy preparation, its purpose, onset, aseptic technique, injection site rotation, complications and local allergic reactions; 4) Measures to detect and relieve edema, monitor weight; 5) Signs/Symptoms of heart attack; 6) Exercise within cardiac limitations, exercise regimen, complications, risk factors; 7)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Signs/Symptoms of coronary artery disease, prevention, importance of diet and exercise; 8) Bladder/bowel incontinence : Care and management; 9) Signs/Symptoms of urinary tract infection: including pain, foul odor, cloudy or blood tinged urine; 10) Cardiac dysfunction: Recognize and relieve complications; 11) Activity to alleviate constipation; 12) Nitroglycerine: when to take, 13) Medications: Side effects, medication reactions to report to physician or skilled nurse, precautions for high risk medications.</p> <p>6. On 2/10/14 at 12 Noon, Employee A indicated there was no further documentation to review for the certification periods and the plan of care was not followed at the nurse visits.</p> <p>7. The undated agency policy titled "Physician's Plan of Care" stated, "Skilled nursing and other home health services should be provided in accordance with a plan of care."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the Plan of Care had orders for therapy for 1 of 6 records reviewed (#3) with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #3, start of care 2-23-13, included a plan of care for the certification period 12-20-13 to 2-17-14</p>	N000524	1,2,3 : Physician telephone order given to the surveyor during survey. Physical therapy to evaluate dated 01/24/2014. Telephone order with physical therapy frequency dated 01/27/2014. The surveyor only asked for skilled nurse and home health aide clinical documentations. Physical therapy not included in the plan of care because it was started in the middle of certification. The Executive director/DON inserviced all the skilled staff that	02/21/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>with physician ordered skilled nursing visits to take place 1-2 times weekly for 8 weeks and home health aide visits to take place 2 times weekly for 8 weeks. The plan of care failed to evidence an order for physical therapy services.</p> <p>2. On 2/7/14 at 10:00 AM, patient #3 was observed receiving physical therapy services from an agency contract employee (employee I). The Power of Attorney/primary care giver for patient #3 indicated patient #3 had improved with the physical therapy, gaining strength and was going to the dining room for meals.</p> <p>3. On 2-10-14 at 9:45 AM employee A indicated there was no further documentation for review.</p> <p>4. The agency policy titled "Plan of Care HH5-3A, HH5-5B, HH5-5A", undated, indicated skilled nursing and other home health services should be provided in accordance with a plan of care and "Verbal/telephone orders shall be obtained from the patients physician for changes in the Plan of Care."</p>		<p>medical care shall follow a written plan of care established and reviewed for appropriateness and effectiveness. Plan of care should include an order for any services that needed according to patient needs. 15% of the clinical records will be audited quarterly to check if plan of care is complete including order of skilled services provided and therapy modalities and changes of services. The Executive director/DON will be responsible for monitoring this action to ensure that this deficiency is corrected and will not recur. 4.) The Executive director/DON has inserviced all skilled staff that medical care should follow are written plan of care established and reviewed for appropriateness and effectiveness. Plan of care should be individualized and consistently reviewed to ensure that the patient needs are met and will be updated as necessary. Verbal/telephone orders shall be obtained from attending physician for any changes in the plan of care that serves as an addendum to plan of care to specify the changes being observed during skilled visit. 15% of clinical records will be audited quarterly to check if there is any verbal/telephone orders obtained from the attending physician for any changes in the plan of care. The Executive director/DON will be responsible for monitoring this action to ensure that this</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on interview and medical record review, the agency failed to ensure the registered nurse notified the physician of a change in a patient's condition for 1 (#2) of 6 records reviewed with the potential to affect all patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #2, start of care 9/24/13, failed to evidence that the physician was notified of a patient having decreased appetite and diminished lung sounds..</p> <p>a. The medical record evidenced a skilled nurse visit took place 11/26/13. Employee N, a registered nurse, documented under "Respiratory" with a "check" in the box next to "Within Normal Limits."</p> <p>b. On 11/30/13, employee N documented under "Respiratory: Lung</p>	N000527	<p>deficiency is corrected and will not recur.</p> <p>1.) a,b,c,d,e,f : The Executive director/DON has inserviced all skilled staffs that medical care shall follow a written plan of care established and reviewed for appropriateness and effectiveness. Plan of care should be individualized and consistently reviewed to ensure that patient care needs are met and updated as necessary. Clinical record should be reviewed and assessment be complete and documented appropriately. Any changes with the patient condition should be reported to the attending physician that warrants immediate attention and change in the plan of care. 15% of the clinical record will be audited and reviewed accordingly for proper documentation and to check if any changes in the patient condition are reported to the attending physician and if there is any changes in the plan of care. The Executive director/DON will be responsible for monitoring this action to ensure that this deficiency is corrected and will not recur. 2.) The Executive director/DON inserviced all the</p>	02/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Sounds- Diminished lower bases, SOB (Shortness of Breath) walking more than 20 feet, climbing stairs."</p> <p>c. On 12/5/13, employee N documented under "Respiratory: Diminished lung sound lower bases" with no further assessment.</p> <p>d. On 12/13/13 employee N documented that the patient was not eating because she was "not hungry." Lung sounds were documented being diminished in the lower bases. No further assessment was documented.</p> <p>e. On 12/18/13, 12/28/13, 1/4/14, 1/10/14, and 1/17/14, employee N documented under "Respiratory: Diminished lung sound lower bases, SOB walking more than 20 feet, climbing stairs." No further assessment was documented.</p> <p>f. The record failed to evidence the physician was contacted regarding the change from the baseline assessment 11/26/13.</p> <p>2. Review of the policy, "Medical Supervision", undated, states: "Physician will be contacted when any of the following occurs: a. Condition changes. b. Expected response to</p>		<p>skilled staff that the physician will be contacted when any of the following occurs: Condition changes, expected response to treatment, medication changes, laboratory results are received, caregiver support, or home environment changes, or any change in patient condition or agency service. 15% of all clinical records will be reviewed quarterly for proper documentation and reporting if there's a need that warrants immediate attention to the physician and any change in the plan of care. The Executive director/DON will be responsible for monitoring this action to ensure that this deficiency is corrected and will not recur.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N000532	<p>treatment or medication changes. c. Laboratory results are received. d. Caregiver support or home environment changes. e. Any change in patient condition or agency services."</p> <p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on interview and medical record review, the agency failed to ensure the registered nurse notified the physician of a change in a patient's condition for 1 (#2) of 6 records reviewed with the potential to affect all patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #2, start of care 9/24/13, failed to evidence that the physician was notified of a patient having decreased appetite and diminished lung sounds..</p> <p>a. The medical record evidenced a</p>	N000532	<p>1.) a,b,c,d,e,f: The Executive director/DON has inserviced all skilled staff that medical care shall follow a written plan of care established and reviewed for appropriateness and effectiveness. Clinical record should be reviewed frequently. Assessment should be completed with proper documentation. Any changes in the patient condition should be reported to the attending physician that warrants immediate attention and to document any change in the plan of care. 15% of the clinical record will be audited and reviewed quarterly for proper documentation and reporting to the attending physician for any change in the patient condition and any change in the plan of care. The Executive director/DON</p>	02/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>skilled nurse visit took place 11/26/13. Employee N, a registered nurse, documented under "Respiratory" with a "check" in the box next to "Within Normal Limits."</p> <p>b. On 11/30/13, employee N documented under "Respiratory: Lung Sounds- Diminished lower bases, SOB (Shortness of Breath) walking more than 20 feet, climbing stairs."</p> <p>c. On 12/5/13, employee N documented under "Respiratory: Diminished lung sound lower bases" with no further assessment.</p> <p>d. On 12/13/13 employee N documented that the patient was not eating because she was "not hungry." Lung sounds were documented being diminished in the lower bases. No further assessment was documented.</p> <p>e. On 12/18/13, 12/28/13, 1/4/14, 1/10/14, and 1/17/14, employee N documented under "Respiratory: Diminished lung sound lower bases, SOB walking more than 20 feet, climbing stairs." No further assessment was documented.</p> <p>f. The record failed to evidence the physician was contacted regarding the</p>		<p>will be responsible for monitoring this action to ensure this deficiency is corrected and will not recur.2.) The Executive director/DON inserviced all staff that physician shall be contacted when any of the following occurs: condition change, expected response to treatment, medication changes,laboratory results are received, caregiver support or home environment changes, or any change in patient condition or ageny services.15% of the clinical record will be reviewed and audited quarterly for proper documentation and reporting to attending physician for any change in the patient condition and change in the plan of care.The Executive director/DON will be responsible for monitoring this action to ensure this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N000546	<p>change from the baseline assessment 11/26/13.</p> <p>2. Review of the policy, "Medical Supervision", undated, states: "Physician will be contacted when any of the following occurs: a. Condition changes. b. Expected response to treatment or medication changes. c. Laboratory results are received. d. Caregiver support or home environment changes. e. Any change in patient condition or agency services."</p> <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>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014	
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on interview and medical record review, the agency failed to ensure the registered nurse notified the physician of a change in a patient's condition for 1 (#2) of 6 records reviewed with the potential to affect all patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #2, start of care 9/24/13, failed to evidence that the physician was notified of a patient having decreased appetite and diminished lung sounds.</p> <p>a. The medical record evidenced a skilled nurse visit took place 11/26/13. Employee N, a registered nurse, documented under "Respiratory" with a "check" in the box next to "Within Normal Limits."</p> <p>b. On 11/30/13, employee N documented under "Respiratory: Lung Sounds- Diminished lower bases, SOB (Shortness of Breath) walking more than 20 feet, climbing stairs."</p> <p>c. On 12/5/13, employee N documented under "Respiratory: Diminished lung sound lower bases" with no further assessment.</p>	N000546	<p>The Executive director/DON has inserviced all skilled staff that under the scope of services the staff shall inform the physician and other appropriate medical personnel for changes in the patient conditions and needs. Counsel the patient and family in meeting nursing and related needs during skilled visit, attends inservice programs and supervise and teach other nursing personnel. 15% of clinical records will be reviewed and audited quarterly for proper documentation and reporting to the attending physician any change in patient condition and change in the plan of care. The Executive director/DON will be responsible for monitoring this action to ensure that this deficiency is corrected and will not recur. 1.) a,b,c,d,e,f: The Executive director/DON has inserviced all skilled staff that the physician should be inform of any changes in patient conditions and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice program and supervise and teach other nursing personnel. 15% of the clinical record will be audited and reviewed quarterly for proper assessment and documentation and reporting to the attending physician and other health personnel any change in patient condition and any change in the plan of care. The Executive</p>	02/21/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>d. On 12/13/13 employee N documented that the patient was not eating because she was "not hungry." Lung sounds were documented being diminished in the lower bases. No further assessment was documented.</p> <p>e. On 12/18/13, 12/28/13, 1/4/14, 1/10/14, and 1/17/14, employee N documented under "Respiratory: Diminished lung sound lower bases, SOB walking more than 20 feet, climbing stairs." No further assessment was documented.</p> <p>f. The record failed to evidence the physician was contacted regarding the change from the baseline assessment 11/26/13.</p> <p>2. Review of the policy, "Medical Supervision", undated, states: "Physician will be contacted when any of the following occurs: a. Condition changes. b. Expected response to treatment or medication changes. c. Laboratory results are received. d. Caregiver support or home environment changes. e. Any change in patient condition or agency services."</p>		<p>director/DON will be responsible for monitoring this action to ensure that this deficiency is corrected and will not recur.2.) The Executive director/DON has inserviced all skilled staff that physician will be contacted when any of the following occur: condition changes, expected response to treatment, medication changes, laboratory result are recieved, caregiver support, or home environment changes, or any change in patient condition or agency services.15% of all clinical record will be audited and reviewed quarterly for proper documentation and reporting to the attending physician for any change in patient condition and change in plan of care.The Executive director/DON will be the overall responsible for monitoring this action to ensure that this deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N000547	<p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse documented a physician's verbal order and only accepted orders from the physician for 1 of 6 (#6) skilled nursing records reviewed with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #6, start of care, 12/4/13, evidenced a skilled nurse note completed by the registered nurse 12/7/13 in which the nurse indicated talking with the physician's assistant for the patient's doctor and receiving orders to hold the dose of a beta blocker the patient was taking, and the patient was to receive a new medication, an antibiotic, Amoxicillin. There were no verbal physician orders in the record related to holding the beta blocker medication or for Amoxicillin.</p> <p>2. The agency policy titled "Physician</p>	N000547	<p>1.) The Executive director/DON inserviced all skilled staff regarding physician telephone orders. Any medication order should be verified with the physician and a verbal/telephone order should be written, sent to the physician for signature and filed in the clinical record. 15% of all clinical record will be audited and reviewed quarterly if any orders documented in the skilled visit has verbal/telephone order sent, signed by the physician and filed in the clinical record. The Executive director/DON will be responsible for monitoring this action to ensure that this deficiency is corrected and will not recur. 2.) The Executive director/DON inserviced all staff the regarding physician telephone order. If the patient or caregiver initiated changes that have been communicated to them by physician, the nurse or therapist will write and date the order the day he/she is informed of the change, but shall indicate in the order the actual day the change was made. The Executive director/DON will be responsible</p>	02/21/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N000565	<p>Telephone Order" with no effective date stated, "If the patient or caregiver initiated changes that have been communicated to them by the physician, the nurse or therapist will write and date the order the day he/she is informed of the change, but shall indicate on the order the actual day the change was made."</p> <p>3. On 2-10-14 at 12 Noon, Employee A indicated there was no further documentation available.</p> <p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); Based on policy review, record review and staff interview, the agency failed to ensure the therapist obtained orders before providing services for 1 of 2 records (#3) reviewed of patients who received physical therapy services with the potential to affect all patients of the agency receiving therapy services.</p>	N000565	<p>for monitoring this action to ensure this deficiency is corrected and will not recur.</p> <p>1,2,3,4 : Physical therapy physician telephone order was provided to the surveyor dated to evaluate on 01/24/2014. Telephone order with physical therapy frequency visit dated 01/27/2014. Physical therapy not included in the plan of care because it was started in the middle of the certification</p>	02/21/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings include:</p> <ol style="list-style-type: none"> <li>Record #3, start of care 2-23-13, included a plan of care for the certification period 12/20/13-2/17/14 with orders for the skilled nurse to visit 1-2 times a week for 8 weeks and the home health aide to visit 2 times weekly for 8 weeks. The plan of care failed to evidence orders for physical therapy to evaluate or treat the patient.</li> <li>At home visit on 2/7/14 at 10:00 AM, patient #3 was observed to be receiving physical therapy from a contract employee of the agency, Employee I.</li> <li>On 2-10-14 at 12 Noon, Employee A indicated there was no further chart documentation to offer for review.</li> <li>The agency policy titled "Plan of Care", undated, indicated skilled nursing and other home health services should be provided in accordance with a plan of care. "Verbal/telephone order shall be obtained from the patient's physician for changes in the Plan of Care."</li> </ol>		<p>period. The Executive director/DON inserviced all skilled staff that the physician telephone order should be in the clinical record before providing services. Verbal/telephone order shall be obtained from the patient's physician. Change in the plan of care should be documented as well. 15% of the clinical record will be audited and reviewed quarterly to check if there is telephone order or verbal order in the clinical record before the services starts and if there is any order for change in condition or change in the plan of care. The Executive director/DON will be responsible for monitoring this action to ensure that this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2014
NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <ol style="list-style-type: none"> <li>(1) The medical plan of care and appropriate identifying information.</li> <li>(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.</li> <li>(3) Drug, dietary, treatment, and activity orders.</li> <li>(4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.</li> <li>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</li> <li>(6) A discharge summary.</li> </ol> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the record included the complete plan of care for 1 of 6 records reviewed (clinical record #1).</p> <p>Findings include:</p>	N000608	1,2,3: The plan of care page #2 was provided to the surveyor. Faxed copy signed by the physician was received in the office but page #2 was included when they returned the copy. The Executive director/DON inserviced all the office	02/21/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ALPHA HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1. Clinical record #1 included a plan of care for the certification period 11/13/13-1/13/14. Page 2 of the 4 page document was missing.</p> <p>2. On 2/10/14 at 10:00 AM, Employee A indicated the plan of care was incomplete, there was no further documentation for review, and the agency was working on the issue.</p> <p>3. The agency policy titled "Plan of Care", undated, states, "The written plan of care must be signed by the Physician and returned to the agency. A copy of the Plan of Care shall be maintained within the patient's clinical record until the original Plan of Care is returned."</p>		<p>employees to make sure to check all the copies of the plan of care received are complete and signed by the physician before filing in the clinical record. 15% of the clinical record will be reviewed and audited quarterly to check if the plan of care pages are complete and signed by the physician before filing in the clinical record. The Executive director/DON will be responsible in monitoring this action to ensure that this deficiency is corrected and will not recur.</p>	