

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
--------------------	--	---------------	---	----------------------

G 000 Bldg. 00	<p>This visit was for a federal home health recertification survey that resulted in an extended survey.</p> <p>Survey Dates: February 18, 19, 20, and 23, 2015.</p> <p>Facility #: 12928</p> <p>Medicaid #: 201091400</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Scott's Home Healthcare LLC is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning February 23, 2015, through February 23, 2017, for being found to be out of compliance with the Conditions of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision and 484.48: Clinical Records.</p> <p>Agency Census: 107 Skilled Patients: 15 Home Health Aide: 106 Personal Services Only: 1</p>	G 000		
-----------------------	---	-------	--	--

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: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 108 Bldg. 00	<p>Quality Review: Joyce Elder, MSN, BSN, RN March 24, 2015</p> <p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the patient was informed, in advance, of any changes in the care to be furnished in 3 of 7 active patient records reviewed creating the potential to affect all 107 of the agency's patients. (#2, #5, and #10)</p> <p>Findings include:</p>	G 108	<p>Appropriate staff to be in serviced on the following: The Home Health Agency (HHA) created a policy entitled "Patient Care Scheduling" which states that Case Manager will notify Scheduling employee of requested days and time of home health visits. Scheduling will maintain a set schedule as requested. If a change to the scheduled visit is requested by the patient, a Communication Form is completed by the</p>	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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 #2 contained a physicians plan of care for certification period 12/2/14 to 1/30/15 with orders to include home health aide services 1 hour per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/10/15 and 1/11/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/24/15, signed by employee BB (home health aide), titled "Home Health Aide Daily Note." The document states, "Time In 10:00 am Time Out 11:00 am."</p> <p>B. The record evidenced a document dated 1/25/15, signed by employee BB, titled "Home Health Aide Daily Note." The document states, "Time In 10:00 am Time Out 11:00 am."</p> <p>C. On 2/20/15 at 9 AM, a home visit was conducted with patient #2. The patient indicated the home health aide is supposed to come at 9 AM every day for 1 hour. The patient indicated a few times the aide came at 10 AM instead of 9 AM and indicated not being notified of the change in arrival time. The patient indicated not having an aide for the dates of Saturday, 1/10/15 and Sunday, 1/11/15 and on 1/10/15, the patient</p>		<p>scheduling employee, the assigned Case Manager is notified immediately, and the request resolution documented for the Case Manager to sign. The completed Communication Form is given to the Administrator for review and to ensure the request was fulfilled. Administrator will file in the patient clinical chart under the appropriate non clinical documentation tab to ensure continuity of care. The Missed Visit Form was revised to include specifically when the patient was notified of a visit that was unable to be filled along with every home health aide called for coverage. Scheduling, Case Managers, and HR Department will meet daily to discuss any unfilled visits for the current work week, problems that need resolved regarding patient scheduled visits, or missed visit documentation that needs completed. Administrator will oversee these morning huddle sessions and Assistant to the Administrator will type summary for review and to ensure that all problems in morning huddle were resolved before end of work day. On Call employees to call into office and report to Administrator at end of shift to report any concerns that need addressed in the on call report. Administrator responsible for ensuring these concerns are addressed and resolved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>contacted the office and spoke with employee CC (office staff) who reassured patient that an aide would arrive on 1/11/15. The patient indicated the aide failed to arrive again on 1/11/15 at which time the patient contacted the office and spoke to employee CC and was told the employee would "Look into it." The patient indicated not being contacted back from the agency.</p> <p>D. On 2/23/15 at 12:35 PM, employee E (alternate director of nursing) indicated it is the responsibility of the on-call staff to contact the patient and inform them of any changes or time differences for the scheduled visit.</p> <p>2. Clinical record #5 contained a physicians plan of care for certification period 1/16/15 to 3/16/15 with orders to include home health aide services 6 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/29/15 and 2/10/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record contained an undated document titled "Missed Visit Form" stating, "Patient: [patient #5] Date/Time of visit: 1/29/15 Type of Visit: HHA [home health aide] Staff Member:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>[Employee FF-home health aide] Reason: Other 'aide off on dr. [doctor] note, couldn't find replacement' How were the patient's needs met? [blank] Physician Notified: [blank]"</p> <p>B. The record contained a document titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The record evidenced the next skilled nursing visit was conducted on 2/13/15 and failed to evidence the patient was notified of the change in the plan of care.</p> <p>1.) The record evidenced a physicians order from the wound center stating, "Date: 2/09/15 Time: 1500 ... Orders Note: Only those items checked will be carried out. ... DIAGNOSIS: Number/Location Wound #(s): '#3' Location: '[left] axilla' Dressing Orders Aquacel Ag/Gauze/Medipore ... Cleanse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Wound(s) with: Normal Saline ... Physician or Physician Extender Signature: [physician at wound center] Date: 2/9/15 Time: 1525"</p> <p>2.) A document titled "Clinical Note" states, "2-9-15 St. [Saint] Joseph Wound Center sent orders for pt [patient] to have daily dressing changes to wound to [left] axilla. Case manager notified. MD aware. Will begin dressing change 2/10/15 after pt receives wound care supplies. [employee K-registered nurse]." The document states, "2-10-15 Pt called et [and] stated [patient] hasn't received [patient's] supplies for wound care. Pt concerned about when wound care will start. Call [physician] at St. Joseph Wound Center to see if staff has ordered supplies. [employee K]." The document states, "2-12-15 1145 A [AM] - St. Joseph Wound Center called et stated pts supplies are now delivered. Called pts PCP [primary care physician] et notified him that office had order for wound care daily. MD stated to start wound care 2/13/15. [employee K]."</p> <p>3.) On 2/19/15 at 3:50 PM, employee K (registered nurse) indicated receiving a call from patient #5 on 2/10/15 with concerns of the skilled nurse not visiting for wound care. The employee indicated contacting the wound</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>center on 2/10/15 in regards to wound care supplies. The employee indicated he/she failed to make contact with the patient in regards to plan for treatment.</p> <p>3. Clinical record #10 contained a physician's plan of care for certification period 12/17/14 to 2/14/15 with orders to include home health aide services 3 hours per day, 5 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/6/15, 1/9/15, and 1/12/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-6-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>B. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-9-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>C. The record evidenced a document dated 1/21/15 titled "MISSED VISIT</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 110	<p>FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-12-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>D. On 2/23/15 at 1:16 PM, employee D (administrator) indicated being unable to locate documentation of patient notification of the missed visits. The employee indicated the missed visit form needs to include documentation of how the patient's needs were met and documentation of any attempts of replacement.</p> <p>4. The agency policy with an effective date of 7/20/15, a revised date of 8/20/12, and a reviewed date as 7/25/14 titled "PATIENT RIGHTS AND RESPONSIBILITIES" states, "PATIENT'S RIGHTS ... 5. You have the right to expect the agency to have the proper resources to render safe care of the frequency of visits proposed. 6. You have the right to be told in advance what disciplines will furnish care and the frequency of visits proposed. ... 8 You have the right to know in advance of any change in your plan of care before the change is made."</p> <p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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	
Bldg. 00	<p>PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on document and policy review, clinical record review, and observation, the agency failed to ensure patients were provided the current Advance Directives, including a description of applicable State law, for 3 of 3 home visit observations creating the potential to affect all 107 of the agency's current patients. (#2, #5, and #6)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 10/8/13, failed to evidence the patient had been presented an updated Advanced Directives document, revised July 2013.</p> <p>On 2/20/15 at 9 AM, a home visit was conducted to patient #2. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p>	G 110	<p>The appropriate staff to be in serviced on the following: The HHA will provide an updated and revised Indiana Advanced Directives document dated July 2013 to every existing patient's home. The assigned Case Manager will provide this document furnished by the HHA during every admission of a patient along with delivering document to existing patients during scheduled supervisory visits, skilled nurse visits, and/or recertification visit determined by first available encounter. Every existing patient to have revised and updated Advanced Directives dated July 13, 2013 in patient residence within 30 days of written correction. Administrator to ensure deficiency corrected and maintained by receiving a list in 30 days from each Case Manager with documentation of completion.</p>	03/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>2. Clinical record #5, start of care 9/18/14, failed to evidence the patient had been presented an updated Advanced Directives document, revised July 2013.</p> <p>On 2/19/15 at 10:15 AM, a home visit was conducted to patient #5. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>3. Clinical record #6, start of care 6/20/14, failed to evidence the patient had been presented an updated Advanced Directives document, revised July 2013.</p> <p>On 2/20/15 at 10 AM, a home visit was conducted to patient #6. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>4. The policy with an effective date of 7/20/12 and reviewed date as 7/25/14 titled "CLIENT CLINICAL RECORD" states, "PROCEDURE: ... 9. The clinical record documents the following, using a standardized format, (clinical note): ... D. Information on any advance directives for care, as appropriate;"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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	
G 121 Bldg. 00	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>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 clinical record review, agency policy review, observation and interview, the agency failed to ensure staff followed infection control practices for 1 of 5 home visit observations and failed to ensure the clinical record contained appropriately authenticated and dated clinical notes as required by agency policy in 1 of 10 clinical records reviewed creating the potential to affect all patients of the agency. (#4 and #5)</p> <p>Findings include:</p> <p>1. During a home visit observation on 2/19/15 at 11 AM, employee J (licensed practical nurse), was observed providing wound care to patient #5. After donning clean gloves, employee J prepped a table with the wound care supplies, cleansed the wound with normal saline on a gauze pad and then placed the pad in a trash bag, applied Aquacel Ag wound pad inside the wound, covered with a sterile gauze pad, applied tape to secure, removed gloves and placed in trash bag, and then washed hands with soap and</p>	G 121	<p>All clinical staff will be required to attend an in service and skills check off regarding proper infection control procedures to be given by contracted licensed medical professional. All staff hired by the HHA will be required to perform a competency skills check off on proper infection control procedures prior to patient contact. All clinical staff will be required to attend and complete a yearly in service including a skills check off to ensure proper infection control practices are being performed and maintained. HR staff to document and track in-service and skills check off. Administrator to receive copy of completion as follow up to ensure compliance is maintained. All Home Health Aide Daily Notes will be completed in entirety by Home Health Aide completing patient visit. Home health aides will complete hha notes according to the policy titled Home Health Aide Note Completion, Auditing, and Correction Policy which states: Policy: Home Health Aide staff will properly complete documentation according to accepted professional standards</p>	03/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>water.</p> <p>A. The agency policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "INFECTION CONTROL" states, "POLICY: All home care staff will follow established infection control procedures. PURPOSE: To provide measures to prevent exposures to infectious diseases during the treatment of patients. PROCEDURE: Standard Precautions/Universal Precautions 1. Standard Precautions are routine barrier precautions that are utilized with all patients to protect employees from contact with blood and body fluids, secretions, excretions, non-intact skin, and mucous membranes. ... 4. Staff should was their hands before and after patient contact, upon removal of gloves, before and after invasive procedures, after handling soiled or contaminated materials, ... and as needed. 5. Medical gloves should be worn when: a) contact with blood or body fluids is likely; b) providing care to non-intact skin; c) handling or cleaning contaminated equipment ... 6. Gloves should be changed between patient contact and procedures. Hands should be washed thoroughly after removal of gloves."</p> <p>B. The agency policy with an</p>		<p>and principles that apply to home health documentation . All documentation is to be properly authenticated by the staff member who completes the work <u>only</u> and patient's will sign home health aide documentation confirming that the clock in and out times, the date, and the checked off tasks were completed on that date between those times according to the plan of care. Procedure: Note Completion- 1. When arriving at patient home, HHA will locate company folder and check careplan for tasks to be completed. 2. Next, HHA will document time of arrival at patient home on nurse aide note on appropriate time. This should be the time HHA was scheduled to be there on his or her calendar. 3. Complete tasks and check them off on note as completed according to the home health aide careplan. Only tasks which have been checked off on hha careplan by the Registered Nurse Supervisor or state "prn" in check box should be addressed/completed at this visit and documented on this note. 4. When visit time comes to end per hha schedule, aide should document end time in appropriate line on hha note and sign on hha signature line and date line next to it. When signing aide is confirming he/she completed the tasks checked as being completed on that date between</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>effective date of 7/20/12 and a reviewed date as 7/25/14 titled "INFECTION CONTROL-HAND WASHING" states, "POLICY: All health care workers shall wash their hands frequently and appropriately. ... Health care workers shall wash hands: ... 4. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes,"</p> <p>2. Clinical record #4, start of care 6/19/14 and discharge date 8/9/14, evidenced a plan of care for certification period 6/20 to 8/18/14 with orders for home health aide services 12 hours per day, 7 days per week for 60 days. The record contained a physicians order for home health aide services 8 hours per day, 7 days per week.</p> <p>A. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee DD-home health aide] Date 6/24/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Partial bed bath [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... Feeds Self [checked] Encourage Fluids [checked] ACTIVITY LEVEL Up with Assistance [checked] W/C [wheelchair] [checked] Partial</p>		<p>the in and out time documented and confirming these were completed in accordance with the HHA careplan. 5. The hha should then request for the patient/or patient family to sign his/her own name on the patient/family signature line and remind them that by doing so they are confirming that the aide was at their home, between the documented times and completed the checked off tasks that were completed in accordance with the hha careplan that the patient was active in helping develop for his/her own care. The patient should also document the date on the date line next to his/her signature. Auditing and Corrections of HHA note- 1. Kokomo HHAs are to turn their notes in each day after their visits are complete. There is a drop box located at the front door of the office building in kokomo. In areas other than Kokomo, a courier is assigned to pick up notes and HHA will be oriented to this when beginning employment. 2. When HHAs turn in notes, they will first be verified in the computer program for time, date and completion of visit. If notes do not match schedule, a copy will be made and forwarded to HR for counseling of scheduler and home health aide. 3. Notes will be audited before filed into the patient record for correctness including: completion in black ink only, tasks completed compared</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Weight Bearing [checked] ... Transfer bed/chair [checked] Transfer toilet [checked] ... ELIMINATION Continent [checked] ... Bedside Commode [checked] ... OTHER ... Medication Reminder [checked] ... HOMEMAKING ... Dishes [checked] ... Other: [checked] ... Employee's Signature [employee DD] Date: '6/24/14' Patient's Signature [name of patient #4] / [signature of employee E-alternate administrator/Director of nursing] Date '6/24/14'."</p> <p>B. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee EE-home health aide] Date 7/4/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Complete bed bath [checked] Assist-Shower [checked] ... Shampoo Hair [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... HOMEMAKING Light housekeeping [checked] ... Dishes [checked] ... Make bed [checked] Trash [checked] Dusting [checked] Sweeping [checked] ... Employee's Signature [employee E] Date: '7/4/14' Patient's Signature [employee E] Date '7/4/14'."</p> <p>On 2/18/15 at 3 PM, employee E</p>		<p>to HHA careplan, and confirmation signatures. Auditor nor anyone in the office will make any type of alteration on the nurse aide note. If notes do not match careplan, are in another color of ink a copy will be made and the copy will be sent to HR for counseling of home health aide. If a signature is missing, the note will be given to the scheduler, the scheduler will contact the home health aide, and the home health aide will be required to get the proper signatures to authenticate the note within 24 hours or a copy will be made of the note and given to HR for counseling/disciplinary service and visit for that note will not be billed. 4. If a home health aide writes the wrong information down during a visit and realizes it during the visit, he or she is to put one line through the incorrect information, write "error" above it, and include date, time and their initials. If these are not completed correctly, auditor will again make a copy of the note and send to HR for HHA counseling. HR to track disciplinary form on employees. Mandatory In Service to be completed by every Home health Aide on proper home health aide daily note completion. The Administrator oversees the nurse management staff and has inserviced the Nursing Supervisor/Alt Administrator and all nurse management staff on</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>indicated the patient had orders for home health aide services 8 hours per day, 7 days per week and the aide frequency was 2 times per day, 4 hours per visit. The employee indicated he/she reviews the aide's documentation of the visit and if something is wrong with the document, he/she corrects it. The employee indicated the 7/4/14 aide visit was performed by employee EE but there must have been something wrong with the aides documentation because employee E had to re-write it. Employee E stated, "I did not make the visit, [name of employee EE] did but there must have been something wrong with the document so I re-did it." Employee E indicated he/she should have wrote employee EE's name where the document states, "Employee's Signature." The employee indicated being unsure of how many times this has occurred.</p> <p>C. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "CLINICAL RECORDS -PURPOSE AND CONTENT" state, "PROCEDURE: Records are documented using professional standards and will contain the following: ... 7. Signed and dated clinical notes for each contact which are written the day of service and incorporated into the patient's clinical record at least weekly."</p>		<p>the HHA note completion policy and has instructed them that immediate termination would be the consequence of violating this policy. HR to track all attendance of mandatory in service to ensure all appropriate staff present. Administrator to instruct in service and provide documented minutes. HR employees to keep all in service tracking documentation and provide upon request. HR to discipline through write up process, any staff that does not complete in service. Non compliant Home Health Aides will not be given scheduled patient visit hours until mandatory in service information has been received. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 143 Bldg. 00	<p>D. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0608" states, "POLICY: Clinical chart order and closed chart order and retention. ... The clinical record will contain pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows. ... All entries must be legible, clear, complete and appropriately authenticated and dated. Authentications must include signatures or a secured computer entry. ..."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record review, observation, policy review, and interview, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively in 1 of 7 active patients reviewed creating the potential to</p>	G 143	Appropriate staff to be in serviced on the following: Case Manager will utilize Coordination of Care Form to be completed at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at each home visit. RN will document any	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>affect all patients of the agency. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained a plan of care for certification period 9/18 to 11/16/14 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>A. The record contained a document signed by employee N (registered nurse) on 9/18/14 titled "Comprehensive Adult Nursing Assessment" stating, "Date '09/18/14' Reason for Visit: Start of Care [checked] ... [page 6 of 20] INTEGUMENTARY STATUS ... Turgor Good Rash Dry Bruises Other (specify) 'redness under abd. [abdominal] folds, under left axilla' ... [page 9 of 20] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Left Axilla [axillary-arm pit]' Type: ... 'Open boil' Size (cm) [centimeter] (LxWxD) [length times width times depth] '1.2 cm x 1.6 cm' ... [page 16 of 20] CARE MANAGEMENT ... d. Medical</p>		<p>findings in the clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made. Policy on pain protocols created to provide proper procedure on identifying pain and addressing with MD for resolution. RN to establish baseline pain upon admission with patient. RN to document in patient assessment document and on 485 assessment. RN to address pain at each nurse visit and supervisory visit. RN to notify MD of any pain identified outside of baseline. RN to document any instructions from MD on resolution of symptoms. RN to notify patient and implement instructions given with patient. RN to document in clinical chart notification and instructions to patient and any/all follow up to ensure resolution. ADON to review all clinical notes written by RN to ensure proper procedures are followed and documentation completed appropriately.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>Procedures/Treatments (e.g. changing wound dressing) 0 [checked] - No Assistance Needed in this Area ... [page 17 of 20] THERAPY AND PLAN OF CARE ... (M2250) Plan of Care Synopsis: ... Plan/Intervention a. Patient-Specific parameters for notifying physician of changes in vital signs or other clinical findings n/a [checked] Not applicable Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference ... Plan/Intervention e. Intervention(s) to monitor and mitigate pain 1 [checked] - Yes" The record failed to evidence the registered nurse addressed the wound with the physician.</p> <p>B. The record contained a document dated 10-14-14 by employee N titled "HHA Supervisory Visit" stating, "Patient Name [patient #5] Date of visit '10-14-14' ... Please list any patient concerns and/or HHA training you feel is needed '[left] armpit - now 3 open areas where draining large amount serosanguineous, slight odor, skin around red'"</p> <p>A document titled "CLINICAL NOTE" states, "10-14-14 During a sup visit nurse asked pt how area under</p>		<p>Administrator to ensure procedure is being followed and compliance is maintained by meeting with ADON daily to review completed documentation findings. Policy created to provide specific scope of practices for Home Health Aides. Copy of policy: Scott's Home Healthcare LLC</p> <p>Job Title: Home Health Aide Effective: 3-30-15</p> <p>No: 606.00</p> <p>Reviewed:</p> <p>Direct Report: RN Case Manager Revised:</p> <p>Primary Purpose: The primary purpose of your job position is to provide high quality home health aide services within the home health aide scope of practice to assigned patients in their place of residence</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>[patients] left axilla was doing and [patient] stated it had been draining even more. Nurse assessed area and pt now has 3 open areas to left axilla that are still draining large amounts of serosanguineous drainage [with] slight odor. skin surround is read and patient reports that [patient's] left arm hurts at times. Nurse call MD office while in home and scheduled appt [appointment] for Friday Oct [October] 17th at 11:30 AM to have the area evaluated. [employee N-registered nurse]." The record failed to evidence the registered nurse followed-up on the patient's 10/17/14 visit with the physician.</p> <p>C. The record contained a document dated 10-20-14 by employee J [LPN-Licensed Practical Nurse] titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 10-20-14 ... Pain Rating '8/10' Pain Area 'arm pit' ... Note: 'med set up completed. Assessment and vs [vital signs] WNL [within normal limits]. Pt to go to ER [emergency room] for outpatient surgery for cyst under [left] arm. Rates pain 8/10 to that area. Discussed safety with transfers. The document failed to evidence the patients pain level (8 out of 10) or the patient's verbal report of outpatient surgery was addressed with the physician or case manager.</p>		<p>with our established policies and procedures, and as may be directed by your RN supervisor.</p> <p>Performance Responsibilities According to Home Health Aide Scope of Practice:</p> <p>A. Patient Care</p> <p>1.Performs personal care activities contained in a written assignment by the Case Manager which includes: Personal hygiene, assisting with ambulation, oral care, skin care, hair care, cooking, feeding, dressing, shaving, vital signs and nail care.</p> <p>1.Assists with/Reminds of Medications – limited to opening and closing a medication container, returning a medication to the proper storage area and assisting in reordering medications from a pharmacy. Home Health aides are not to administer medications including applying prescription creams or powders but may assist patient as needed and as included on home health aide careplan.</p> <p>2.Follows a written plan of care, which includes realistic goals and interventions, which is prepared by</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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. The record contained a document dated 11-3-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-3-14 ... Pain Rating '7/10' Pain Area 'stomach' ... Note: 'med set up completed. Assessment and vs completed WNL. No edema noted. Rates stomach pain 7/10. underarm [left] has 4 holes Pt has medication BID to area. discussed using med as directed'" The record failed to evidence the LPN notified the physician or case manager of the patient's change in wound status and pain rating of 7/10.</p> <p>E. The record contained a document dated 11-10-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-10-14 ... Note: 'Patient continues topical medication to wound in left axilla per MD order. Moderate serosanguineous drainage [with] odor. After pt. lifted [left] arm to put medicine on, moderate amount of dark blood, thick, from 4 areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>F. The record contained a plan of care for certification period 11/17/15 to 1/15/15 with orders to include skilled nursing services 1 time per week for 60</p>		<p>the case manager.</p> <p>3.Performs assigned activities that are taught by an RN.</p> <p>4.Responds to patient needs in a timely manner.</p> <p>5.Provides care in a cost effective manner.</p> <p>6.Treats all patients with kindness and respect</p> <p>7.Completes housekeeping tasks as written and directed on the plan of care...."</p> <p>This policy states that Home Health Aides are not to give any medications to patients. Home Health Aides are allowed, if care plan states, to provide medication reminders to patient. No Home Health Aide will provide any topical application of prescription cream and will follow counseling/disciplinary procedure as needed for violation. Case Conference/Care Pathway form updated to provide specific planning suggestions by clinical staff. RN to complete Case Conference on every existing patient. Once Case Conference planning suggestions have been documented, RN will resolve and document resolution on Case Conference document. All participatory staff will sign document which is to be filed in appropriate binder and kept by ADON. Administrator to review Case Conference resolutions weekly at set nursing staff meeting to ensure compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>G. The record contained a document signed by employee N (registered nurse) on 11/14/14 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? Yes [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 3 [checked] - daily, but not constantly ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: Yes [checked] Location(s) wound</p>		<p>RN to meet with Administrator prior to weekly meeting on any urgent case conference resolutions needed. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>site: 'left axilla' ... Technique: Clean [checked] ... Patient tolerated procedure well: Yes [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd)</p> <p>Wound/Lesion #1 Location 'Proximal Left axilla' Type: 'abscess' Size: '0.6 x 0.5' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #2 Location '[left] axilla' Type: 'abscess' Size: '0.3 x 0.4' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]</p> <p>Wound/Lesion #3 Location '[left] axilla' Type: 'abscess' Size: '0.4 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #4 Location 'lateral [left] axilla' Type: 'abscess' Size: '0.7 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>H. The record contained a document dated 11-24-14 by employee N titled "Nurse Care Visit Note" stating, "Patient</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Name [patient #5] Date '11-24-14' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'Open areas to [left] axilla are now 2, was previously 4 smaller areas. Drainage noted, skin around pink. Pt complains of burning to areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>I. The record contained a document dated 12-8-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '12-8-14' ... Pain Rating '8/10' Pain Area 'Headache [Left] axilla ... Note: 'Pt. compliant [with] medications thru [through] previous week med set up. ... 1.5 cm x 3.1 cm x 0.2 cm deep [with] no tunneling. Serosanguineous drng [drainage] noted.'" The record failed to evidence the RN contacted the physician with the change in wound status and pain of 8 out of 10.</p> <p>J. The record contained a document dated 12-22-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 12-22-14 ... Pain Rating '9/10' Pain Area 'HA [headache]' ... SKIN WNL [checked] ... *Describe rash or wounds in note below including measurements. ... Note: 'med set up completed. Assessment and vs</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>completed WNL. Rates HA 9/10. No edema noted BLE [bilateral lower extremities]. Discussed pt HA's and medication safety'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 9 out of 10.</p> <p>K. The record contained a document dated 1-5-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-5-15' ... Pain Rating 6/10 Pain Area 'back /[left] axilla' SKIN ... * Describe rash or wounds in note below including measurements ... Note: 'Pt compliant [with] meds through previous set up. Pt. tolerates visit well. Complains of headache and pain too back and left axilla wound. Wound has foul odor and drainage noted, MD aware.'" The record failed to evidence documentation of physician notification of wound status and pain rating.</p> <p>L. The record contained a plan of care signed by the attending physician on 1/15/15 for certification period 1/16/15 to 3/16/15 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>activities of daily living] as per home health aide care plan.</p> <p>M. The record contained a document signed by employee N (registered nurse) on 1/12/15 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? No Problem [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 2 [checked] - Less often than daily ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: No [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location '[Left] axilla' Type: 'abscess' Size (cm) (LxWxH [length times width times height]): '2.1 cm x 4.6 cm x 0.2 cm' Tunneling [zero]</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Stage [zero] Odor 'Y' Surrounding Skin 'Intact' Edema 'Y' ... Appearance of the wound bed 'Granulated red' Drainage/Amount Small [checked] Color Serosanguineous [checked] Consistency Thin [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>N. The record contained a document dated 1-26-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-26-15' ... Pain Rating 7/10 Pain Area '[left] Ab [abdominal] fold ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... '[patient] reports MD called [patient] on 1-23-15 and told [patient] to go to the ER to have area on [left] [abdominal] fold drained but said [patient] didn't have a ride and today its too cold'" The record failed to evidence documentation of physician notification of the patient not reporting to the ER for the draining of the abscess.</p> <p>O. The record contained a document dated 2-2-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '2-2-15' ... Pain Rating '8/10' Pain Area 'Headache' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... 'Pt.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>tolerates visit well. ... Area has minimal drainage at this time [with] foul odor. Pt. c/o [complains of] tenderness to area. No s/s [signs and symptoms] of infection noted.'" The record failed to evidenced the RN assessed the wounds (to include measurements), failed to evidence the patient's pain level was addressed, and failed to evidence documentation of physician notification of patient's pain level of 8 out of 10.</p> <p>P. The record contained a document dated 2/9/15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' Time in 4:40 p Time Out 5:00 PM ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Skin *describe rash or wounds in note below including measurements. ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The document failed to evidence the RN had provided wound assessment to include measurements. The record failed to evidence the</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>physician had been notified of the patient's pain rating of an 8 out of a 0-10 scale.</p> <p>A document titled "CLINICAL NOTE" states, "2-10-15 Pt called et [and] stated [patient] hasn't received [patient's] supplies for wound care. Pt concerned about when wound care will start. Call [physician] at St. Joseph Wound Center to see if staff has ordered supplies. [employee K]."</p> <p>Q. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the case manager of the pain level of 7 out of 10 and failed to evidence the LPN assessed the abdominal fold abscess.</p> <p>R. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 7 out of 10.</p> <p>S. The record contained a document titled "HOME HEALTH AIDE CARE PLAN" with a date of review by employee N (registered nurse/case manager) on 1-12-15 to include foot care daily as an assigned task.</p> <p>1.) On 2/19/15 at 10:15 AM, a home visit was conducted with patient #5 to observe care being provided by the home health aide (employee Z). At 10:45 AM, employee Z was asked about the task of providing foot care. The employee indicated after assistance with showering, the employee rubs a cream on the patient's feet. The employee presented the cream to the surveyor at which time it was observed to be a prescription medication of Econazole Nitrate 1% cream, a topical antifungal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>medication. The employee indicated the cream is put on the feet, but not in between the toes, and then the employee will place the patient's socks on "to keep it all in." The employee indicated someone in the office had told her to perform this task about a month ago but could not remember the staff member who told this to her.</p> <p>The record contained a document titled "MEDICATION PROFILE" with a review date of 2/11/15 by employee N (registered nurse/case manager). The document failed to list Econazole Nitrate 1% cream as a current medication used by the patient.</p> <p>2.) On 2/19/15 at 10:55 AM, during the home visit with patient #5, an interview was conducted with employee J (licensed practical nurse) who was present for a scheduled skilled nursing visit. The employee indicated the Econazole Nitrate 1% cream was listed on the medication profile as Cleocin T 1% (a topical antibiotic) and is to be applied to the left axillary wound two times per day. The employee indicated the Cleocin T 1% cream was prescribed on 10/29/14. The employee stated, "This is to be under [patient's] arm, not on her feet."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>3.) On 2/19/15 at 11:05 AM, during the home visit with patient #5, the patient indicated using the Econazole Nitrate 1% cream on his/her feet for a while and it was being used before the wound appeared under the left axillary. The patient indicated the doctor prescribed this to be used on his/her feet and legs.</p> <p>4.) On 2/19/15 at 11:10 AM, during the home visit with patient #5, employee J (licensed practical nurse) notified employee N (registered nurse/case manager) via telephone. Employee J discussed with employee N the use by the patient of the Econazole Nitrate 1% cream and employee J stated to employee N, "On new med sheet, I couldn't find it, the one [medication profile sheet] that you sent, because we got the Eucerin Cream to [patient's] feet and legs. It is on the old one [medication profile sheet] that was here. You have it written as Cleosin, left axillary BID [two times per day] but its not [listed] on the new one [medication profile sheet]." The patient then stated, "I have been using that on my feet and legs before I ever had a hole [wound in left axilla]." The patient indicated is was prescribed by the doctor because of bumps on his/her legs that kept "busting open." Employee J ended the call with employee N and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>indicated the RN (employee N) would have to clarify the Econazole Nitrate 1% cream with the physician because the RN (employee N) was not aware of the patient having that medication.</p> <p>5.) On 2/20/15 at 12:45 PM, an interview was conducted with employee N (registered nurse/ case manager). The employee indicated never seeing the Econazole Nitrate 1% cream in the patient's home before and indicated the patient never told of use this medication. The employee indicated sending a fax to the patient's primary physician on 2/19/15 requesting information on the cream. The employee indicated the cream is to be used BID for rashes. The employee indicated not providing instructions to the home health aide to perform this task.</p> <p>2. A document dated 11/14/14 titled "CASE CONFERENCE" states, "Patient Name [patient #5] Date '11-14-14' Summary of meeting: 'Patient has had abscess under left axilla for few months now. Area had opened and MD was notified. Pt seen MD and referred to surgeon. The surgeon opted for no surgery and gave [patient] medicine to apply daily to area. The wound site is now 4 open holes and [patient] has large dark drainage from areas daily. Pt is able too roll on the medicine to areas but I feel</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>that these haven't been treated properly and aren't healing. Areas need to be washed and irrigated, medicine applied and dry dressing applied to area daily' Meeting Attendees [employee N-case manager/registered nurse] ... [employee W-registered nurse] [employee J-LPN] [employee D-administrator]."</p> <p>A. On 2/19/15 at 4:15 PM, employee E (alternate administrator) indicated the case conference document suggests that the open areas were identified and the need to alter the plan of care should have been addressed but was not.</p> <p>B. On 2/19/15 at 3:15 PM, employee E indicated the skilled nurse should have addressed the wound with the physician on admission.</p> <p>3. On 2/19/15 3:15 PM, employee D (administrator) indicated staff are educated to report increased pain to the physician. The employee indicated being unable to locate documentation of the patient's baseline (tolerable) pain level.</p> <p>4. On 2/20/15 at 12:50 PM, during the interview with employee N (case manager / registered nurse), the employee indicated the patient started services 9/18/14 and upon initial assessment, a wound in the left axillary had been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>identified. The employee indicated, according to the patient, the wound was evaluated by the physician but no orders for treatment were given. Employee N indicated there was no communication with the physician regarding the evaluation of the wound. The employee indicated at the 11/14/14 recertification assessment, the wound was changed and had become 4 small wounds. The employee indicated being unable to locate documentation in the chart of physician notification of this and indicated being unable to locate documentation the chart evidencing a follow-up had been made. Employee N indicated the wounds had another change and the 4 wounds then become 2. The employee indicated being unable to locate documentation in the record to evidence physician notification. Employee N indicated at the 1/12/14 recertification assessment, the 2 wounds had become 1. The employee indicated on 1/19/15, a second wound on the patient's abdominal fold was discovered at which time the physician was notified and an appointment was scheduled for 1/21/15. Employee N indicated on 1/21/15, the patient informed the employee of physician contact and of an appointment scheduled to a surgeon to address the wounds on 2/4/15. The employee indicated the patient was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>directed to go to the ER on 1/23/15 by the physician and have the abscess on the abdominal fold drained but failed to go and the employee indicated being unable to locate documentation in the clinical record of the physician's notification of this.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0484" states, "Communications policy and procedure: PURPOSE: To maintain effective communications to assure that all personnel providing services shall appropriately complement on another and support the objectives of the patient's care. POLICY: Communication regarding patient's care shall be documented in the clinical record. ... Field staff will communicate all pertinent information to nursing supervisor and/or nurse case manager of that patient's case. Nursing supervisors will review any new orders with or information with field staff for cases they are working on. The nursing supervisors will promptly alert the physician of any changes that suggest a need to alter the medical plan of care. ... The nursing supervisor will notify the patient's physician or other appropriate licensed professional staff and legal representatives, if any, of any significant physical or mental changes observed are</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 144 Bldg. 00	<p>reported by the patient. ... "</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PHYSICIAN ORDERS" states, "PROCEDURE: ... 10. The agency will ensure that communication with the physician is timely, appropriate and consistent with the needs of the patient. ... "</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record review, policy review, and interview, the agency failed to ensure case conferences established effective interchange and coordination of patient care had occurred in 1 of 7 active patient records reviewed creating the potential to affect all patient's of the agency. (#5) Findings include: 1. Clinical record #5 contained a plan of</p>	G 144	All appropriate staff to be in serviced on the following: Case Conference Form was modified to incorporate an interaction between all nursing staff in order to problem solve situations that arise in patient status. Nursing staff will meet weekly at a designated time at which case conference forms will be reviewed. Suggestions will be made at this time to help assigned RN with patient concerns. RN will use these suggestions to resolve patient	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>care for certification period 9/18 to 11/16/14 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>A. The record contained a document signed by employee N (registered nurse) on 9/18/14 titled "Comprehensive Adult Nursing Assessment" stating, "Date '09/18/14' Reason for Visit: Start of Care [checked] ... [page 6 of 20] INTEGUMENTARY STATUS ... Turgor Good Rash Dry Bruises Other (specify) 'redness under abd. [abdominal] folds, under left axilla' ... [page 9 of 20] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Left Axilla [axillary-arm pit]' Type: ... 'Open boil' Size (cm) [centimeter] (LxWxD) [length times width times depth] '1.2 cm x 1.6 cm' ... [page 16 of 20] CARE MANAGEMENT ... d. Medical Procedures/Treatments (e.g. changing wound dressing) 0 [checked] - No Assistance Needed in this Area ... [page 17 of 20] THERAPY AND PLAN OF CARE ... (M2250) Plan of Care</p>		<p>concerns. Administrator will review every case conference throughout the week to initiate immediate resolutions if needed prior to weekly nursing meeting. ADON will keep case conference forms in designated binder. Administrator will ensure this process is maintained by reviewing case conference binder monthly for resolutions. Case Conference form will be completed on every active patient. RN will utilize Coordination of Care form to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visit. RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made. Policy on pain protocols created to provide proper procedure on identifying pain and addressing with MD for resolution. RN to establish</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Synopsis: ... Plan/Intervention a. Patient-Specific parameters for notifying physician of changes in vital signs or other clinical findings n/a [checked] Not applicable Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference ... Plan/Intervention e. Intervention(s) to monitor and mitigate pain 1 [checked] - Yes" The record failed to evidence the registered nurse addressed the wound with the physician.</p> <p>B. The record contained a document dated 10-14-14 by employee N titled "HHA Supervisory Visit" stating, "Patient Name [patient #5] Date of visit '10-14-14' ... Please list any patient concerns and/or HHA training you feel is needed '[left] armpit - now 3 open areas where draining large amount serosanguineous, slight odor, skin around red'"</p> <p>A document titled "CLINICAL NOTE" states, "10-14-14 During a sup visit nurse asked pt how area under [patients] left axilla was doing and [patient] stated it had been draining even more. Nurse assessed area and pt now has 3 open areas to left axilla that are still draining large amounts of serosanguineous</p>		<p>baseline pain upon admission with patient. RN to document in patient assessment document and on 485 assessment. RN to address pain at each nurse visit and supervisory visit. RN to notify MD of any pain identified outside of baseline. RN to document any instructions from MD on resolution of symptoms. RN to notify patient and implement instructions given with patient. RN to document in clinical chart notification and instructions to patient and any/all follow up to ensure resolution. ADON to review all clinical notes written by RN to ensure proper procedures are followed and documentation completed appropriately. Administrator to ensure procedure is being followed and compliance is maintained. Communication form created and to be utilized immediately for all calls to scheduler employees by patients and/or home health aides regarding patient status. This form was created to ensure communication regarding patient information is given to assigned patient RN from non clinical staff. Form indicates purpose of call, date and time RN was notified, and resolution. Administrator to review all Communication Forms and file after review into clinical chart under last tab for continuity of care for non clinical staff.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>drainage [with] slight odor. skin surround is read and patient reports that [patient's] left arm hurts at times. Nurse call MD office while in home and scheduled appt [appointment] for Friday Oct [October] 17th at 11:30 AM to have the area evaluated. [employee N-registered nurse]." The record failed to evidence the registered nurse followed-up on the patient's 10/17/14 visit with the physician.</p> <p>C. The record contained a document dated 10-20-14 by employee J [LPN-Licensed Practical Nurse] titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 10-20-14 ... Pain Rating '8/10' Pain Area 'arm pit' ... Note: 'med set up completed. Assessment and vs [vital signs] WNL [within normal limits]. Pt to go to ER [emergency room] for outpatient surgery for cyst under [left] arm. Rates pain 8/10 to that area. Discussed safety with transfers. The document failed to evidence the patients pain level (8 out of 10) or the patient's verbal report of outpatient surgery was addressed with the physician or case manager.</p> <p>D. The record contained a document dated 11-3-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-3-14 ... Pain</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Rating '7/10' Pain Area 'stomach' ... Note: 'med set up completed. Assessment and vs completed WNL. No edema noted. Rates stomach pain 7/10. underarm [left] has 4 holes Pt has medication BID to area. discussed using med as directed'" The record failed to evidence the LPN notified the physician or case manager of the patient's change in wound status and pain rating of 7/10.</p> <p>E. The record contained a document dated 11-10-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-10-14 ... Note: 'Patient continues topical medication to wound in left axilla per MD order. Moderate serosanguineous drainage [with] odor. After pt. lifted [left] arm to put medicine on, moderate amount of dark blood, thick, from 4 areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>F. The record contained a plan of care for certification period 11/17/15 to 1/15/15 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>activities of daily living] as per home health aide care plan.</p> <p>G. The record contained a document signed by employee N (registered nurse) on 11/14/14 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? Yes [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 3 [checked] - daily, but not constantly ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: Yes [checked] Location(s) wound site: 'left axilla' ... Technique: Clean [checked] ... Patient tolerated procedure well: Yes [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Proximal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>Left axilla' Type: 'abscess' Size: '0.6 x 0.5' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #2 Location '[left] axilla' Type: 'abscess' Size: '0.3 x 0.4' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #3 Location '[left] axilla' Type: 'abscess' Size: '0.4 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #4 Location 'lateral [left] axilla' Type: 'abscess' Size: '0.7 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>H. The record contained a document dated 11-24-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '11-24-14' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'Open areas to [left] axilla are now 2, was previously 4 smaller areas.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Drainage noted, skin around pink. Pt complains of burning to areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>I. The record contained a document dated 12-8-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '12-8-14' ... Pain Rating '8/10' Pain Area 'Headache [Left] axilla ... Note: 'Pt. compliant [with] medications thru [through] previous week med set up. ... 1.5 cm x 3.1 cm x 0.2 cm deep [with] no tunneling. Serosanguineous drng [drainage] noted.'" The record failed to evidence the RN contacted the physician with the change in wound status and pain of 8 out of 10.</p> <p>J. The record contained a document dated 12-22-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 12-22-14 ... Pain Rating '9/10' Pain Area 'HA [headache]' ... SKIN WNL [checked] ... *Describe rash or wounds in note below including measurements. ... Note: 'med set up completed. Assessment and vs completed WNL. Rates HA 9/10. No edema noted BLE [bilateral lower extremities]. Discussed pt HA's and medication safety'" The record failed to evidence the LPN notified the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>physician and case manager of the pain level of 9 out of 10.</p> <p>K. The record contained a document dated 1-5-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-5-15' ... Pain Rating 6/10 Pain Area 'back /[left] axilla' SKIN ... * Describe rash or wounds in note below including measurements ... Note: 'Pt compliant [with] meds through previous set up. Pt. tolerates visit well. Complains of headache and pain too back and left axilla wound. Wound has foul odor and drainage noted, MD aware.'" The record failed to evidence documentation of physician notification of wound status and pain rating.</p> <p>L. The record contained a plan of care signed by the attending physician on 1/15/15 for certification period 1/16/15 to 3/16/15 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>M. The record contained a document signed by employee N (registered nurse)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>on 1/12/15 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? No Problem [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 2 [checked] - Less often than daily ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: No [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location '[Left] axilla' Type: 'abscess' Size (cm) (LxWxH [length times width times height]): '2.1 cm x 4.6 cm x 0.2 cm' Tunneling [zero] Stage [zero] Odor 'Y' Surrounding Skin 'Intact' Edema 'Y' ... Appearance of the wound bed 'Granulated red' Drainage/Amount Small [checked] Color Serosanguineous [checked]</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Consistency Thin [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>N. The record contained a document dated 1-26-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-26-15' ... Pain Rating 7/10 Pain Area '[left] Ab [abdominal] fold ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... '[patient] reports MD called [patient] on 1-23-15 and told [patient] to go to the ER to have area on [left] [abdominal] fold drained but said [patient] didn't have a ride and today its too cold'" The record failed to evidence documentation of physician notification of the patient not reporting to the ER for the draining of the abscess.</p> <p>O. The record contained a document dated 2-2-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '2-2-15' ... Pain Rating '8/10' Pain Area 'Headache' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... 'Pt. tolerates visit well. ... Area has minimal drainage at this time [with] foul odor. Pt. c/o [complains of] tenderness to area. No s/s [signs and symptoms] of infection noted.'" The record failed to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>evidenced the RN assessed the wounds (to include measurements), failed to evidence the patient's pain level was addressed, and failed to evidence documentation of physician notification of patient's pain level of 8 out of 10.</p> <p>P. The record contained a document dated 2/9/15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' Time in 4:40 p Time Out 5:00 PM ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Skin *describe rash or wounds in note below including measurements. ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The document failed to evidence the RN had provided wound assessment to include measurements. The record failed to evidence the physician had been notified of the patient's pain rating of an 8 out of a 0-10 scale.</p> <p>A document titled "CLINICAL</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>NOTE" states, "2-10-15 Pt called et [and] stated [patient] hasn't received [patient's] supplies for wound care. Pt concerned about when wound care will start. Call [physician] at St. Joseph Wound Center to see if staff has ordered supplies. [employee K]."</p> <p>Q. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the case manager of the pain level of 7 out of 10 and failed to evidence the LPN assessed the abdominal fold abscess.</p> <p>R. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 7 out of 10.</p> <p>S. The record contained a document titled "HOME HEALTH AIDE CARE PLAN" with a date of review by employee N (registered nurse/case manager) on 1-12-15 to include foot care daily as an assigned task.</p> <p>1.) On 2/19/15 at 10:15 AM, a home visit was conducted with patient #5 to observe care being provided by the home health aide (employee Z). At 10:45 AM, employee Z was asked about the task of providing foot care. The employee indicated after assistance with showering, the employee rubs a cream on the patient's feet. The employee presented the cream to the surveyor at which time it was observed to be a prescription medication of Econazole Nitrate 1% cream, a topical antifungal medication. The employee indicated the cream is put on the feet, but not in between the toes, and then the employee will place the patient's socks on "to keep it all in." The employee indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>someone in the office had told her to perform this task about a month ago but could not remember the staff member who told this to her.</p> <p>The record contained a document titled "MEDICATION PROFILE" with a review date of 2/11/15 by employee N (registered nurse/case manager). The document failed to list Econazole Nitrate 1% cream as a current medication used by the patient.</p> <p>2.) On 2/19/15 at 10:55 AM, during the home visit with patient #5, an interview was conducted with employee J (licensed practical nurse) who was present for a scheduled skilled nursing visit. The employee indicated the Econazole Nitrate 1% cream was listed on the medication profile as Cleocin T 1% (a topical antibiotic) and is to be applied to the left axillary wound two times per day. The employee indicated the Cleocin T 1% cream was prescribed on 10/29/14. The employee stated, "This is to be under [patient's] arm, not on her feet."</p> <p>3.) On 2/19/15 at 11:05 AM, during the home visit with patient #5, the patient indicated using the Econazole Nitrate 1% cream on his/her feet for a while and it was being used before the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>wound appeared under the left axillary. The patient indicated the doctor prescribed this to be used on his/her feet and legs.</p> <p>4.) On 2/19/15 at 11:10 AM, during the home visit with patient #5, employee J (licensed practical nurse) notified employee N (registered nurse/case manager) via telephone. Employee J discussed with employee N the use by the patient of the Econazole Nitrate 1% cream and employee J stated to employee N, "On new med sheet, I couldn't find it, the one [medication profile sheet] that you sent, because we got the Eucerin Cream to [patient's] feet and legs. It is on the old one [medication profile sheet] that was here. You have it written as Cleosin, left axillary BID [two times per day] but its not [listed] on the new one [medication profile sheet]." The patient then stated, "I have been using that on my feet and legs before I ever had a hole [wound in left axilla]." The patient indicated is was prescribed by the doctor because of bumps on his/her legs that kept "busting open." Employee J ended the call with employee N and indicated the RN (employee N) would have to clarify the Econazole Nitrate 1% cream with the physician because the RN (employee N) was not aware of the patient having that medication.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>5.) On 2/20/15 at 12:45 PM, an interview was conducted with employee N (registered nurse/ case manager). The employee indicated never seeing the Econazole Nitrate 1% cream in the patient's home before and indicated the patient never told of use this medication. The employee indicated sending a fax to the patient's primary physician on 2/19/15 requesting information on the cream. The employee indicated the cream is to be used BID for rashes. The employee indicated not providing instructions to the home health aide to perform this task.</p> <p>2. A document dated 11/14/14 titled "CASE CONFERENCE" states, "Patient Name [patient #5] Date '11-14-14' Summary of meeting: 'Patient has had abscess under left axilla for few months now. Area had opened and MD was notified. Pt seen MD and referred to surgeon. The surgeon opted for no surgery and gave [patient] medicine to apply daily to area. The wound site is now 4 open holes and [patient] has large dark drainage from areas daily. Pt is able to roll on the medicine to areas but I feel that these haven't been treated properly and aren't healing. Areas need to be washed and irrigated, medicine applied and dry dressing applied to area daily' Meeting Attendees [employee N-case</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>manager/registered nurse] ... [employee W-registered nurse] [employee J-LPN] [employee D-administrator]."</p> <p>A. On 2/19/15 at 4:15 PM, employee E (alternate administrator) indicated the case conference document suggests that the open areas were identified and the need to alter the plan of care should have been addressed but was not.</p> <p>B. On 2/19/15 at 3:15 PM, employee E indicated the skilled nurse should have addressed the wound with the physician on admission.</p> <p>3. On 2/19/15 3:15 PM, employee D (administrator) indicated staff are educated to report increased pain to the physician. The employee indicated being unable to locate documentation of the patient's baseline (tolerable) pain level.</p> <p>4. On 2/20/15 at 12:50 PM, during the interview with employee N (case manager / registered nurse), the employee indicated the patient started services 9/18/14 and upon initial assessment, a wound in the left axillary had been identified. The employee indicated, according to the patient, the wound was evaluated by the physician but no orders for treatment were given. Employee N indicated there was no communication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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 the physician regarding the evaluation of the wound. The employee indicated at the 11/14/14 recertification assessment, the wound was changed and had become 4 small wounds. The employee indicated being unable to locate documentation in the chart of physician notification of this and indicated being unable to locate documentation the chart evidencing a follow-up had been made. Employee N indicated the wounds had another change and the 4 wounds then become 2. The employee indicated being unable to locate documentation in the record to evidence physician notification. Employee N indicated at the 1/12/14 recertification assessment, the 2 wounds had become 1. The employee indicated on 1/19/15, a second wound on the patient's abdominal fold was discovered at which time the physician was notified and an appointment was scheduled for 1/21/15. Employee N indicated on 1/21/15, the patient informed the employee of physician contact and of an appointment scheduled to a surgeon to address the wounds on 2/4/15. The employee indicated the patient was directed to go to the ER on 1/23/15 by the physician and have the abscess on the abdominal fold drained but failed to go and the employee indicated being unable to locate documentation in the clinical</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>record of the physician's notification of this.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0484" states, "Communications policy and procedure: PURPOSE: To maintain effective communications to assure that all personnel providing services shall appropriately complement on another and support the objectives of the patient's care. POLICY: Communication regarding patient's care shall be documented in the clinical record. ... Field staff will communicate all pertinent information to nursing supervisor and/or nurse case manager of that patient's case. Nursing supervisors will review any new orders with or information with field staff for cases they are working on. The nursing supervisors will promptly alert the physician of any changes that suggest a need to alter the medical plan of care. ... The nursing supervisor will notify the patient's physician or other appropriate licensed professional staff and legal representatives, if any, of any significant physical or mental changes observed are reported by the patient."</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PHYSICIAN ORDERS" states,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 156 Bldg. 00	<p>"PROCEDURE: ... 10. The agency will ensure that communication with the physician is timely, appropriate and consistent with the needs of the patient."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record review, home visit observation, policy review, and interview, it was determined the agency failed to ensure visits were made as ordered on the plan of care in 4 of 7 active patients records reviewed creating the potential to affect all 107 patients of the agency (See G 158); failed to ensure the plan of care included medications in 1 of 10 clinical records reviewed creating the potential to affect all patient ' s of the agency (See G 159); and failed to ensure agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care in 1 of 7 active patient records reviewed (See G 164).</p> <p>The cumulative effect of this systemic problem resulted in the agency ' s inability to meet the requirements of the Condition of Participation 484.18 Acceptance of Patients, Plan of Care, Medical Supervision.</p>	G 156	All appropriate staff to be in serviced on the following: RN to review medication profile, care plan, and pain at every visit including supervisory visits, skilled nursing visits, and assessments requested by MD order. RN to notify MD of any changes found from medication profile review or patient notification to RN and document findings and notification in clinical chart. ADON to review every visit form to ensure these tasks are completed. ADON to utilize follow up form to track any concerns RN needs to address and review with RN to ensure follow up. Administrator to meet with ADON daily to review these concerns and ensure follow up and documentation completed. Policy created to ensure consistent patient scheduling visit times. RN to request and discuss time frame at admission for scheduling home health visits with patient of record. Once admission is complete, RN to call in admission information to ADON who will take completed information to	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 158 Bldg. 00	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.		appropriate scheduling employee to initiate scheduling of patient home health services. As per the information given at admission, the assigned scheduler will coordinate with the patient to ensure the home health visits are scheduled at the patient requested time and will e maintained at that time unless requested otherwise by the patient. In the instance an employee cannot fulfill the scheduled home health visit, the assigned scheduler will make every attempt to find an alternative home health aide to complete the patient's scheduled visit. The patient will maintain communication with the assigned scheduler regarding this process and the alteration of the time of visit, if any. Patients will be notified immediately by the assigned scheduler if any alteration in patient schedule time must be made due to unforeseen circumstances. Documentation will be made on a Communication Form, given to the assigned RN and placed in the chart of record once reviewed by the Administrator to ensure compliance of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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 clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care in 4 of 7 active patients reviewed creating the potential to affect all 107 patients of the agency. (#2, #5, #6, and #10)</p> <p>Findings include:</p> <p>1. Clinical record #2 contained a physicians plan of care for certification period 12/2/14 to 1/30/15 with orders to include home health aide services 1 hour per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/10/15 and 1/11/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. On 2/20/15 at 9 AM, a home visit was conducted with patient #2. The patient indicated not having an aide for the dates of Saturday, 1/10/15 and Sunday, 1/11/15 and on 1/10/15, the patient contacted the office and spoke with employee CC (office staff) who reassured patient that an aide would arrive on 1/11/15. The patient indicated the aide failed to arrive again on 1/11/15 at which time the patient contacted the office and spoke to employee CC and was told the employee would "Look into</p>	G 158	<p>All appropriate staff to be in serviced on the following: Daily huddles to be completed with each member of scheduling, case management, and HR every morning. At this time weekly schedules to be reviewed, indicating any unfilled visits, concerns, and missed visits that need addressed due to absences by home health aides. Daily Huddle Form to be utilized to ensure these topics are addressed. Assistant to Administrator to collect all forms and compile summary for Administrator. Administrator to ensure resolution occurs on all unfilled visits or concerns covered in daily huddle by end of business day. A policy has been established to address compliance with the agency responsibility to meet the needs of the patient once accepted into care. Patients will not be accepted for admission if the agency is not able to meet the needs of the patient upon initial assessment. The established policy is as follows:Policy: It is the policy of the company to maintain patient care consistency per M.D. orders. As part of this policy it must be acknowledged that there are two types of missed visits. One, being a patient cancellation and tow, being agency staff cancellation.PROCEDURE:1) Patient cancellation: will be addressed if the patient</p>	03/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>it." The patient indicated not being contacted back from the agency.</p> <p>B. On 2/23/15 at 12:35 PM, employee E (alternate director of nursing) indicated it is the responsibility of the on-call staff to contact the patient and inform them of any changes or time differences for the scheduled visit.</p> <p>C. On 2/23/15 at 12:55 PM, employee E indicated being unable to locate documentation related to the missed home health aide visits on 1/10 and 1/11/15.</p> <p>2. Clinical record #5 contained a physicians plan of care for certification period 1/16/15 to 3/16/15 with orders to include home health aide services 6 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/29/15 and 2/10/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>The record contained an undated document titled "Missed Visit Form" stating, "Patient: [patient #5] Date/Time of visit: 1/29/15 Type of Visit: HHA [home health aide] Staff Member: [Employee FF-home health aide] Reason: Other 'aide off on dr. [doctor]</p>		<p>cancellation causes non compliance with the physician's order. A missed visit form will be completed and given to the Administrator and CM Nurse. Administrator to log in Missed Visit Log for tracking. If the patient has more than two cancellations within the current certification period, the patient will be discharged according to policy.2) Agency staff cancellation will be addressed by utilizing all other home health aide staff, on call home health aide, all available agency staff from the scheduling staff, up the organizational chart, to the Administrator in order to maintain compliance. Non compliance with this policy is unacceptable and scheduling staff will be terminated if policy is not maintained. Communication forms to be utilized by scheduling and completed on every phone call taken regarding home health aide or patient. Once concern is documented, RN to be notified immediately to inform of situation. RN to instruct on resolution if scheduling can complete. Patient to be called back and documentation completed on every concern or request. Once resolution is completed and RN has signed and documented, all completed forms to go to Administrator for review and filing. Communication Form to be filed in patient chart, last tab, to ensure continuity of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>note, couldn't find replacement' How were the patient's needs met? [blank] Physician Notified: [blank]"</p> <p>3. Clinical record #6 contained a physicians plan of care for certification period 12/31/14 to 2/28/15 with orders to include home health aide services 3 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/6/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>The record evidenced a document dated 1/14/15 by employee N (registered nurse) titled "MISSED VISIT FORM" stating, "Patient: [patient #6] Date/Time of Visit: '1-6-15 10 A -1 P' Type of Visit: 'HHA [home health aide]' ... Reason: Other [checked] 'HHA called off and couldn't fill hours' How were patient's needs met? [blank]"</p> <p>4. Clinical record #10 contained a physicians plan of care for certification period 12/17/14 to 2/14/15 with orders to include home health aide services 3 hours per day, 5 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/6/15, 1/9/15, and 1/12/15 and failed to evidence documentation of the patient's</p>		<p>care, and show communication between scheduling, nursing and patient. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-6-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>B. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-9-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>C. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-12-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>D. On 2/23/15 at 1:16 PM, employee D (administrator) indicated being unable to locate documentation of patient notification of the missed visits. The employee indicated the missed visit form needs to include documentation of how the patient's needs were met and documentation of any attempts of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 159 Bldg. 00	<p>replacement.</p> <p>5. The agency policy with an effective date as 7/20/12 and a reviewed date of 7/25/14 titled "MISSED VISIT" states, "POLICY: It is the policy of the company to maintain patient care consistency per M.D. [medical doctor] orders. ... PROCEDURE: 1. A missed visit occurs when the physician-ordered frequency of services is not maintained. ... 3. A missed visit constitutes a modification in the plan of care and the physician must be notified."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record review, policy review, observation, and interview, the</p>	G 159	All appropriate staff to be in serviced on the following: Medication Profile will be	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>agency failed to ensure the plan of care included medications in 1 of 10 clinical records reviewed creating the potential to affect all patient's of the agency. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained plan of care for certification period 1/16/15 to 3/16/15 with orders to include skilled nursing services and home health aide services. The plan of care failed to include an updated medication list.</p> <p>A. On 2/19/15 at 10:15 AM, a home visit was conducted with patient #5 to observe care being provided by the home health aide (employee Z). At 10:45 AM, employee Z was asked about the task of providing foot care. The employee indicated after assistance with showering, the employee rubs a cream on the patient's feet. The employee presented the cream to the surveyor at which time it was observed to be a prescription medication of Econazole Nitrate 1% cream (a topical antifungal cream). The employee indicated the cream is put on the feet, but not in between the toes, and then the employee will place the patient's socks on "to keep it all in." The employee indicated someone in the office had told her to perform this task about a month ago but could not remember the</p>		<p>reviewed at every patient visit including supervisory visits, skilled nursing visits, recertification and any assessment per MD order. ADON to review all completed visit/assessment documentation. Monthly audits to be completed to ensure medication review was completed on each patient during visits. Patient letter given to every patient upon admission stating patient to inform RN by calling office if any changes in medications occur between scheduled visits. If medication changes occur, RN will add medication to Medication Profile in patient home and clinical chart. RN will notify MD to verify change and document in clinical note. ADON will review all clinical documentation and monitor any follow up needed. Administrator will meet daily with ADON to ensure RN has followed up, resolution/documentation is complete and compliance is maintained.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>staff member who told this to her.</p> <p>The record contained a document titled "MEDICATION PROFILE" with a review date of 2/11/15 by employee N (registered nurse/case manager). The document and the plan of care failed to list Econazole Nitrate 1% cream as a current medication used by the patient.</p> <p>B. The document titled "MEDICATION PROFILE" (with a review date of 2/11/15 by employee N) and the plan of care failed to list Cleocin T 1% as a medication presently being used by the patient.</p> <p>C. On 2/19/15 at 11:05 AM, during the home visit with patient #5, the patient indicated using the Econazole Nitrate 1% cream on his/her feet for a while and it was being used before the wound appeared under the left axillary. The patient indicated the doctor prescribed this to be used on his/her feet and legs.</p> <p>D. On 2/19/15 at 11:10 AM, during the home visit with patient #5, employee J (licensed practical nurse) notified employee N (registered nurse/case manager) via telephone. Employee J discussed with employee N the use by the patient of the Econazole Nitrate 1% cream and employee J stated to employee</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>N, "On new med sheet, I couldn't find it, the one [medication profile sheet] that you sent, because we got the Eucerin Cream to [patient's] feet and legs. It is on the old one [medication profile sheet] that was here. You have it written as Cleosin, left axillary BID [two times per day] but its not [listed] on the new one [medication profile sheet]." The patient then stated, "I have been using that on my feet and legs before I ever had a hole [wound in left axillary]." The patient indicated is was prescribed by the doctor because of bumps on his/her legs that kept "busting open." Employee J ended the call with employee N and indicated the RN (employee N) would have to clarify the Econazole Nitrate 1% cream with the physician because the RN (employee N) was not aware of the patient having that medication.</p> <p>E. On 2/20/15 at 12:45 PM, an interview was conducted with employee N (registered nurse / case manager). The employee indicated never seeing the Econazole Nitrate 1% cream in the patient's home before and indicated the patient never told of use this medication.</p> <p>2. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "Plan of Care" states, "POLICY: A written plan of care shall be developed</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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			
G 164 Bldg. 00	<p>for each client admitted to home care for skilled treatment in consultation with the home health professional staff, the patient's physician, the patient and members of the patient's family. PURPOSE: 1. To ensure delivery of health care services that are medically required for the client. ... PROCEDURE: Plan of Treatment ... 3. The plan of care will include physician orders for Medications and Treatments"</p> <p>3. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PATIENT MEDICATION" states, "PROCEDURE Administration of Medications ... 11. The current medication profile, listing medications, home remedies, over the counter drugs and side effects, will be recorded on the client medication form and maintained in the client's record."</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record review, policy review, and interview, the agency failed to ensure agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care in 1 of 7 active patient's records reviewed. (#5)</p>	G 164	All appropriate staff to be in serviced on the following: RN will utilize Coordination of Care form to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visit. RN will document any	03/30/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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> <p>1. Clinical record #5 contained a plan of care for certification period 9/18 to 11/16/14 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>A. The record contained a document signed by employee N (registered nurse) on 9/18/14 titled "Comprehensive Adult Nursing Assessment" stating, "Date '09/18/14' Reason for Visit: Start of Care [checked] ... [page 6 of 20] INTEGUMENTARY STATUS ... Turgor Good Rash Dry Bruises Other (specify) 'redness under abd. [abdominal] folds, under left axilla' ... [page 9 of 20] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Left Axilla [axillary-arm pit]' Type: ... 'Open boil' Size (cm) [centimeter] (LxWxD) [length times width times depth] '1.2 cm x 1.6 cm' ... [page 16 of 20] CARE MANAGEMENT ... d. Medical Procedures/Treatments (e.g. changing</p>		<p>findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made. Policy on pain protocols created to provide proper procedure on identifying pain and addressing with MD for resolution. RN to establish baseline pain upon admission with patient. RN to document in patient assessment document and on 485 assessment. RN to address pain at each nurse visit and supervisory visit. RN to notify MD of any pain identified outside of baseline. RN to document any instructions from MD on resolution of symptoms. RN to notify patient and implement instructions given with patient. RN to document in clinical chart notification and instructions to patient and any/all follow up to ensure resolution. ADON to review all clinical notes written by RN to ensure proper procedures are followed and documentation completed appropriately.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>wound dressing) 0 [checked] - No Assistance Needed in this Area ... [page 17 of 20] THERAPY AND PLAN OF CARE ... (M2250) Plan of Care Synopsis: ... Plan/Intervention a. Patient-Specific parameters for notifying physician of changes in vital signs or other clinical findings n/a [checked] Not applicable Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference ... Plan/Intervention e. Intervention(s) to monitor and mitigate pain 1 [checked] - Yes" The record failed to evidence the registered nurse addressed the wound with the physician.</p> <p>B. The record contained a document dated 10-20-14 by employee J [LPN-Licensed Practical Nurse] titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 10-20-14 ... Pain Rating '8/10' Pain Area 'arm pit' ... Note: 'med set up completed. Assessment and vs [vital signs] WNL [within normal limits]. Pt to go to ER [emergency room] for outpatient surgery for cyst under [left] arm. Rates pain 8/10 to that area. Discussed safety with transfers. The document failed to evidence the patients pain level (8 out of 10) or the patient's verbal report of</p>		Administrator to ensure procedure is being followed and compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>outpatient surgery was addressed with the physician or case manager.</p> <p>C. The record contained a document dated 11-3-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-3-14 ... Pain Rating '7/10' Pain Area 'stomach' ... Note: 'med set up completed. Assessment and vs completed WNL. No edema noted. Rates stomach pain 7/10. underarm [left] has 4 holes Pt has medication BID to area. discussed using med as directed'" The record failed to evidence the LPN notified the physician or case manager of the patient's change in wound status and pain rating of 7/10.</p> <p>D. The record contained a document dated 11-10-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-10-14 ... Note: 'Patient continues topical medication to wound in left axilla per MD order. Moderate serosanguineous drainage [with] odor. After pt. lifted [left] arm to put medicine on, moderate amount of dark blood, thick, from 4 areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>E. The record contained a document signed by employee N (registered nurse)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>on 11/14/14 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? Yes [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 3 [checked] - daily, but not constantly ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: Yes [checked] Location(s) wound site: 'left axilla' ... Technique: Clean [checked] ... Patient tolerated procedure well: Yes [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Proximal Left axilla' Type: 'abscess' Size: '0.6 x 0.5' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #2</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Location '[left] axilla' Type: 'abscess' Size: '0.3 x 0.4' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]</p> <p>Wound/Lesion #3 Location '[left] axilla' Type: 'abscess' Size: '0.4 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #4 Location 'lateral [left] axilla' Type: 'abscess' Size: '0.7 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>F. The record contained a document dated 11-24-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '11-24-14' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'Open areas to [left] axilla are now 2, was previously 4 smaller areas. Drainage noted, skin around pink. Pt complains of burning to areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>G. The record contained a document dated 12-8-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '12-8-14' ... Pain Rating '8/10' Pain Area 'Headache [Left] axilla ... Note: 'Pt. compliant [with] medications thru [through] previous week med set up. ... 1.5 cm x 3.1 cm x 0.2 cm deep [with] no tunneling. Serosanguineous drng [drainage] noted.'" The record failed to evidence the RN contacted the physician with the change in wound status and pain of 8 out of 10.</p> <p>H. The record contained a document dated 12-22-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 12-22-14 ... Pain Rating '9/10' Pain Area 'HA [headache]' ... SKIN WNL [checked] ... *Describe rash or wounds in note below including measurements. ... Note: 'med set up completed. Assessment and vs completed WNL. Rates HA 9/10. No edema noted BLE [bilateral lower extremities]. Discussed pt HA's and medication safety'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 9 out of 10.</p> <p>I. The record contained a document dated 1-5-15 by employee N titled "Nurse</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Care Visit Note" stating, "Patient Name [patient #5] Date '1-5-15' ... Pain Rating 6/10 Pain Area 'back /[left] axilla' SKIN ... * Describe rash or wounds in note below including measurements ... Note: 'Pt compliant [with] meds through previous set up. Pt. tolerates visit well. Complains of headache and pain too back and left axilla wound. Wound has foul odor and drainage noted, MD aware.'"</p> <p>The record failed to evidence documentation of physician notification of wound status and pain rating.</p> <p>J. The record contained a document signed by employee N (registered nurse) on 1/12/15 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? No Problem [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>patient's active or movement: 2 [checked] - Less often than daily ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: No [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location '[Left] axilla' Type: 'abscess' Size (cm) (LxWxH [length times width times height]): '2.1 cm x 4.6 cm x 0.2 cm' Tunneling [zero] Stage [zero] Odor 'Y' Surrounding Skin 'Intact' Edema 'Y' ... Appearance of the wound bed 'Granulated red' Drainage/Amount Small [checked] Color Serosanguineous [checked] Consistency Thin [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>K. The record contained a document dated 1-26-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-26-15' ... Pain Rating 7/10 Pain Area '[left] Ab [abdominal] fold ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... '[patient] reports MD called [patient] on 1-23-15 and told [patient] to go to the ER to have area on [left] [abdominal] fold drained but said [patient] didn't have a ride and today its too cold'" The record failed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>to evidence documentation of physician notification of the patient not reporting to the ER for the draining of the abscess.</p> <p>L. The record contained a document dated 2-2-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '2-2-15' ... Pain Rating '8/10' Pain Area 'Headache' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... 'Pt. tolerates visit well. ... Area has minimal drainage at this time [with] foul odor. Pt. c/o [complains of] tenderness to area. No s/s [signs and symptoms] of infection noted.'" The failed to evidence documentation of physician notification of patient's pain level of 8 out of 10.</p> <p>M. The record contained a document dated 2/9/15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' Time in 4:40 p Time Out 5:00 PM ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Skin *describe rash or wounds in note below including measurements. ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The record failed to evidence the physician had been notified of the patient's pain rating of an 8 out of a 0-10 scale.</p> <p>N. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 7 out of 10.</p> <p>2. On 2/19/15 3:15 PM, employee D (administrator) indicated staff are educated to report increased pain to the physician. The employee indicated being unable to locate documentation of the patient's baseline (tolerable) pain level.</p> <p>3. On 2/20/15 at 12:45 PM, an interview with employee N (case</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>manager/registered nurse) was conducted. The employee indicated the patient started services 9/18/14 and upon initial assessment, a wound in the left axillary had been identified. The employee indicated, according to the patient, the wound was evaluated by the physician but no orders for treatment were given. Employee N indicated there was no communication with the physician regarding the evaluation of the wound. The employee indicated at the 11/14/14 recertification assessment, the wound was changed and had become 4 small wounds. The employee indicated being unable to locate documentation in the chart of physician notification of this and indicated being unable to locate documentation the chart evidencing a follow-up had been made. Employee N indicated the wounds had another change and the 4 wounds then become 2. The employee indicated being unable to locate documentation in the record to evidence physician notification. Employee N indicated at the 1/12/14 recertification assessment, the 2 wounds had become 1. The employee indicated on 1/19/15, a second wound on the patient's abdominal fold was discovered at which time the physician was notified and an appointment was scheduled for 1/21/15. Employee N indicated on 1/21/15, the patient informed the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>employee of physician contact and of an appointment scheduled to a surgeon to address the wounds on 2/4/15. The employee indicated the patient was directed to go to the ER on 1/23/15 by the physician and have the abscess on the abdominal fold drained but failed to go and the employee indicated being unable to locate documentation in the clinical record of the physician's notification of this.</p> <p>4. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "Plan of Care" states, "POLICY: A written plan of care shall be developed for each client admitted to home care for skilled treatment in consultation with the home health professional staff, the patient's physician, the patient and members of the patient's family. PURPOSE: 1. To ensure delivery of health care services that are medically required for the client. ... PROCEDURE: Plan of Treatment 1. Home health services are furnished to clients under the physician's certification that the services are medically required for the client. ... 2. The plan of care for each patient will include: ... All pertinent diagnoses ... 4. The forms: Oasis Start of Care (initial assessment), Patient medications, assessment summary, physician's orders and patient problem list constitute the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Plan of Care and are submitted by the case manager and professional team members to the agency within 4 working days of the start of care date. ... 6. RN [registered nurse] case manager, therapists promptly inform the physician of any changes that suggest a need to alter the plan of care. 7. All changes in the plan of care are documented through written and signed physician orders."</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0484" states, "Communications policy and procedure: PURPOSE: To maintain effective communications to assure that all personnel providing services shall appropriately complement on another and support the objectives of the patient's care. POLICY: Communication regarding patient's care shall be documented in the clinical record. ... Field staff will communicate all pertinent information to nursing supervisor and/or nurse case manager of that patient's case. Nursing supervisors will review any new orders with or information with field staff for cases they are working on. The nursing supervisors will promptly alert the physician of any changes that suggest a need to alter the medical plan of care. ... The nursing supervisor will notify the patient's physician or other appropriate licensed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>professional staff and legal representatives, if any, of any significant physical or mental changes observed are reported by the patient. ... "</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PHYSICIAN ORDERS" states, "POLICY: Every patient will have an individualized plan of care based on the medical, functional and psychosocial needs of each patient. Home care staff shall administer care and treatment according to the specific individualized instructions of the patient;s designated primary physician. ... PURPOSE: ... 2. To facilitate quality improvement in the receipt of physician orders. ... PROCEDURE: 1. Physician orders are initiated when physician or referral source requests skilled services, and required prior any care is initiated, either verbally or in writing. ... 3. Physician verbal or telephone orders for care are recorded and verified by appropriate qualified and licensed professional staff members. ... A. The physician will be notified immediately of any changes in the patient's condition which indicate changes to the plan of treatment. ... Medical Supervision ... 10. The agency will ensure that communication with the physician is timely, appropriate and consistent with the needs of the patient.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 176 Bldg. 00	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review, policy review, observation and interview, the agency failed to ensure the registered nurse coordinated services and informed the physician and other personnel of changes in the patient's condition and needs in 1 of 7 active patient records reviewed creating the potential to affect all patients of the agency. (#5)</p> <p>Findings include:</p> <p>Based on clinical record review, observation, policy review, and interview, the agency failed to ensure all personnel furnishing services maintained</p>	G 176	<p>Appropriate staff to be in serviced on the following: Policy on pain protocols created to provide proper procedure on identifying pain and addressing with MD for resolution. RN to establish baseline pain upon admission with patient. RN to document in patient assessment document and on 485 assessment. RN to address pain at each nurse visit and supervisory visit. RN to notify MD of any pain identified outside of baseline. RN to document any instructions from MD on resolution of symptoms. RN to notify patient and implement instructions given with patient. RN to document in clinical chart</p>	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>liaison to ensure that their efforts were coordinated effectively in 1 of 7 active patients reviewed creating the potential to affect all patients of the agency. (#5)</p> <p>Findings include:</p> <p>Related to communication of personnel</p> <p>1. Clinical record #5 contained a plan of care for certification period 9/18 to 11/16/14 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>A. The record contained a document signed by employee N (registered nurse) on 9/18/14 titled "Comprehensive Adult Nursing Assessment" stating, "Date '09/18/14' Reason for Visit: Start of Care [checked] ... [page 6 of 20] INTEGUMENTARY STATUS ... Turgor Good Rash Dry Bruises Other (specify) 'redness under abd. [abdominal] folds, under left axilla' ... [page 9 of 20] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Left Axilla [axillary-arm pit]'</p>		<p>notification and instructions to patient and any/all follow up to ensure resolution. In the instance the skilled visit is performed by the LPN, the LPN will utilize the Communication Form to communicate with the appropriate CM findings regarding the patient in order to maintain continuity of care to all medical providers involved in care. ADON to review all clinical notes written by RN to ensure proper procedures are followed and documentation completed appropriately. Administrator to ensure procedure is being followed and compliance is maintained. Home Health Agency to provide supplies for any wound care ordered by MD until supplies are delivered in order to provide continuity of care to patient. RN to notify Administrator of needs. Account set up at Moore's Home health store in order to allow RN to purchase supplies needed. Medication Profile will be reviewed at every patient visit including supervisory visits, skilled nursing visits, recertification and any assessment per MD order. ADON to review all completed visit/assessment documentation. Monthly audits to be completed to ensure medication review was completed on each patient during visits. Patient letter given to every patient upon admission stating patient to inform RN by calling office if any changes in</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Type: ... 'Open boil' Size (cm) [centimeter] (LxWxD) [length times width times depth] '1.2 cm x 1.6 cm' ... [page 16 of 20] CARE MANAGEMENT ... d. Medical Procedures/Treatments (e.g. changing wound dressing) 0 [checked] - No Assistance Needed in this Area ... [page 17 of 20] THERAPY AND PLAN OF CARE ... (M2250) Plan of Care Synopsis: ... Plan/Intervention a. Patient-Specific parameters for notifying physician of changes in vital signs or other clinical findings n/a [checked] Not applicable Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference ... Plan/Intervention e. Intervention(s) to monitor and mitigate pain 1 [checked] - Yes" The record failed to evidence the registered nurse addressed the wound with the physician.</p> <p>B. The record contained a document dated 10-14-14 by employee N titled "HHA Supervisory Visit" stating, "Patient Name [patient #5] Date of visit '10-14-14' ... Please list any patient concerns and/or HHA training you feel is needed '[left] armpit - now 3 open areas where draining large amount serosanguineous, slight odor, skin around</p>		<p>medications occur between scheduled visits. If medication changes occur, RN will add medication to Medication Profile in patient home and clinical chart. RN will notify MD to verify change and document in clinical note. ADON will review all clinical documentation and monitor any follow up needed. Administrator will meet daily with ADON to ensure RN has followed up and resolution/documentation is complete. Case Conference/Care Pathway form updated to provide specific planning suggestions by clinical staff. RN to complete Case Conference on every existing patient. Once Case Conference planning suggestions have been documented, RN will resolve and document resolution on Case Conference document. All participatory staff will sign document which is to be filed in appropriate binder and kept by ADON. Administrator to review Case Conference resolutions weekly at set nursing staff meeting to ensure compliance. RN will utilize Coordination of Care form created to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visits. RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>red'"</p> <p>A document titled "CLINICAL NOTE" states, "10-14-14 During a sup visit nurse asked pt how area under [patients] left axilla was doing and [patient] stated it had been draining even more. Nurse assessed area and pt now has 3 open areas to left axilla that are still draining large amounts of serosanguineous drainage [with] slight odor. skin surround is read and patient reports that [patient's] left arm hurts at times. Nurse call MD office while in home and scheduled appt [appointment] for Friday Oct [October] 17th at 11:30 AM to have the area evaluated. [employee N-registered nurse]." The record failed to evidence the registered nurse followed-up on the patient's 10/17/14 visit with the physician.</p> <p>C. The record contained a document dated 10-20-14 by employee J [LPN-Licensed Practical Nurse] titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 10-20-14 ... Pain Rating '8/10' Pain Area 'arm pit' ... Note: 'med set up completed. Assessment and vs [vital signs] WNL [within normal limits]. Pt to go to ER [emergency room] for outpatient surgery for cyst under [left] arm. Rates pain 8/10 to that area. Discussed safety with</p>		document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>transfers. The document failed to evidence the patients pain level (8 out of 10) or the patient's verbal report of outpatient surgery was addressed with the physician or case manager.</p> <p>D. The record contained a document dated 11-3-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-3-14 ... Pain Rating '7/10' Pain Area 'stomach' ... Note: 'med set up completed. Assessment and vs completed WNL. No edema noted. Rates stomach pain 7/10. underarm [left] has 4 holes Pt has medication BID to area. discussed using med as directed'" The record failed to evidence the LPN notified the physician or case manager of the patient's change in wound status and pain rating of 7/10.</p> <p>E. The record contained a document dated 11-10-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-10-14 ... Note: 'Patient continues topical medication to wound in left axilla per MD order. Moderate serosanguineous drainage [with] odor. After pt. lifted [left] arm to put medicine on, moderate amount of dark blood, thick, from 4 areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>F. The record contained a plan of care for certification period 11/17/15 to 1/15/15 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>G. The record contained a document signed by employee N (registered nurse) on 11/14/14 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? Yes [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 3 [checked] - daily, but not</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>constantly ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: Yes [checked] Location(s) wound site: 'left axilla' ... Technique: Clean [checked] ... Patient tolerated procedure well: Yes [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Proximal Left axilla' Type: 'abscess' Size: '0.6 x 0.5' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #2 Location '[left] axilla' Type: 'abscess' Size: '0.3 x 0.4' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #3 Location '[left] axilla' Type: 'abscess' Size: '0.4 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #4 Location 'lateral [left] axilla' Type: 'abscess' Size: '0.7 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>time of recertification.</p> <p>H. The record contained a document dated 11-24-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '11-24-14' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'Open areas to [left] axilla are now 2, was previously 4 smaller areas. Drainage noted, skin around pink. Pt complains of burning to areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>I. The record contained a document dated 12-8-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '12-8-14' ... Pain Rating '8/10' Pain Area 'Headache [Left] axilla ... Note: 'Pt. compliant [with] medications thru [through] previous week med set up. ... 1.5 cm x 3.1 cm x 0.2 cm deep [with] no tunneling. Serosanguineous drng [drainage] noted.'" The record failed to evidence the RN contacted the physician with the change in wound status and pain of 8 out of 10.</p> <p>J. The record contained a document dated 12-22-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 12-22-</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>14 ... Pain Rating '9/10' Pain Area 'HA [headache]' ... SKIN WNL [checked] ... *Describe rash or wounds in note below including measurements. ... Note: 'med set up completed. Assessment and vs completed WNL. Rates HA 9/10. No edema noted BLE [bilateral lower extremities]. Discussed pt HA's and medication safety'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 9 out of 10.</p> <p>K. The record contained a document dated 1-5-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-5-15' ... Pain Rating 6/10 Pain Area 'back /[left] axilla' SKIN ... * Describe rash or wounds in note below including measurements ... Note: 'Pt compliant [with] meds through previous set up. Pt. tolerates visit well. Complains of headache and pain too back and left axilla wound. Wound has foul odor and drainage noted, MD aware.'" The record failed to evidence documentation of physician notification of wound status and pain rating.</p> <p>L. The record contained a plan of care signed by the attending physician on 1/15/15 for certification period 1/16/15 to 3/16/15 with orders to include skilled nursing services 1 time per week for 60</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>M. The record contained a document signed by employee N (registered nurse) on 1/12/15 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? No Problem [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 2 [checked] - Less often than daily ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: No [checked] ... [page 6 of 14]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location '[Left] axilla' Type: 'abscess' Size (cm) (LxWxH [length times width times height]): '2.1 cm x 4.6 cm x 0.2 cm' Tunneling [zero] Stage [zero] Odor 'Y' Surrounding Skin 'Intact' Edema 'Y' ... Appearance of the wound bed 'Granulated red' Drainage/Amount Small [checked] Color Serosanguineous [checked] Consistency Thin [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>N. The record contained a document dated 1-26-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-26-15' ... Pain Rating 7/10 Pain Area '[left] Ab [abdominal] fold ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... '[patient] reports MD called [patient] on 1-23-15 and told [patient] to go to the ER to have area on [left] [abdominal] fold drained but said [patient] didn't have a ride and today its too cold'" The record failed to evidence documentation of physician notification of the patient not reporting to the ER for the draining of the abscess.</p> <p>O. The record contained a document dated 2-2-15 by employee N titled "Nurse</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Care Visit Note" stating, "Patient Name [patient #5] Date '2-2-15' ... Pain Rating '8/10' Pain Area 'Headache' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... 'Pt. tolerates visit well. ... Area has minimal drainage at this time [with] foul odor. Pt. c/o [complains of] tenderness to area. No s/s [signs and symptoms] of infection noted.'" The record failed to evidenced the RN assessed the wounds (to include measurements), failed to evidence the patient's pain level was addressed, and failed to evidence documentation of physician notification of patient's pain level of 8 out of 10.</p> <p>P. The record contained a document dated 2/9/15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' Time in 4:40 p Time Out 5:00 PM ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Skin *describe rash or wounds in note below including measurements. ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ...</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Nurse Signature [employee N-registered nurse]" The document failed to evidence the RN had provided wound assessment to include measurements. The record failed to evidence the physician had been notified of the patient's pain rating of an 8 out of a 0-10 scale.</p> <p>A document titled "CLINICAL NOTE" states, "2-10-15 Pt called et [and] stated [patient] hasn't received [patient's] supplies for wound care. Pt concerned about when wound care will start. Call [physician] at St. Joseph Wound Center to see if staff has ordered supplies. [employee K]."</p> <p>Q. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the case manager of the pain level of 7 out of 10 and failed to evidence the LPN assessed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>the abdominal fold abscess.</p> <p>R. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 7 out of 10.</p> <p>S. The record contained a document titled "HOME HEALTH AIDE CARE PLAN" with a date of review by employee N (registered nurse/case manager) on 1-12-15 to include foot care daily as an assigned task.</p> <p>1.) On 2/19/15 at 10:15 AM, a home visit was conducted with patient #5 to observe care being provided by the home health aide (employee Z). At 10:45 AM, employee Z was asked about the task of providing foot care. The employee indicated after assistance with showering, the employee rubs a cream on</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>the patient's feet. The employee presented the cream to the surveyor at which time it was observed to be a prescription medication of Econazole Nitrate 1% cream, a topical antifungal medication. The employee indicated the cream is put on the feet, but not in between the toes, and then the employee will place the patient's socks on "to keep it all in." The employee indicated someone in the office had told her to perform this task about a month ago but could not remember the staff member who told this to her.</p> <p>The record contained a document titled "MEDICATION PROFILE" with a review date of 2/11/15 by employee N (registered nurse/case manager). The document failed to list Econazole Nitrate 1% cream as a current medication used by the patient.</p> <p>2.) On 2/19/15 at 10:55 AM, during the home visit with patient #5, an interview was conducted with employee J (licensed practical nurse) who was present for a scheduled skilled nursing visit. The employee indicated the Econazole Nitrate 1% cream was listed on the medication profile as Cleocin T 1% (a topical antibiotic) and is to be applied to the left axillary wound two times per day. The employee indicated</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>the Cleocin T 1% cream was prescribed on 10/29/14. The employee stated, "This is to be under [patient's] arm, not on her feet."</p> <p>3.) On 2/19/15 at 11:05 AM, during the home visit with patient #5, the patient indicated using the Econazole Nitrate 1% cream on his/her feet for a while and it was being used before the wound appeared under the left axillary. The patient indicated the doctor prescribed this to be used on his/her feet and legs.</p> <p>4.) On 2/19/15 at 11:10 AM, during the home visit with patient #5, employee J (licensed practical nurse) notified employee N (registered nurse/case manager) via telephone. Employee J discussed with employee N the use by the patient of the Econazole Nitrate 1% cream and employee J stated to employee N, "On new med sheet, I couldn't find it, the one [medication profile sheet] that you sent, because we got the Eucerin Cream to [patient's] feet and legs. It is on the old one [medication profile sheet] that was here. You have it written as Cleosin, left axillary BID [two times per day] but its not [listed] on the new one [medication profile sheet]." The patient then stated, "I have been using that on my feet and legs before I ever had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>a hole [wound in left axilla]." The patient indicated is was prescribed by the doctor because of bumps on his/her legs that kept "busting open." Employee J ended the call with employee N and indicated the RN (employee N) would have to clarify the Econazole Nitrate 1% cream with the physician because the RN (employee N) was not aware of the patient having that medication.</p> <p>5.) On 2/20/15 at 12:45 PM, an interview was conducted with employee N (registered nurse/ case manager). The employee indicated never seeing the Econazole Nitrate 1% cream in the patient's home before and indicated the patient never told of use this medication. The employee indicated sending a fax to the patient's primary physician on 2/19/15 requesting information on the cream. The employee indicated the cream is to be used BID for rashes. The employee indicated not providing instructions to the home health aide to perform this task.</p> <p>2. A document dated 11/14/14 titled "CASE CONFERENCE" states, "Patient Name [patient #5] Date '11-14-14' Summary of meeting: 'Patient has had abscess under left axilla for few months now. Area had opened and MD was notified. Pt seen MD and referred to surgeon. The surgeon opted for no</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>surgery and gave [patient] medicine to apply daily to area. The wound site is now 4 open holes and [patient] has large dark drainage from areas daily. Pt is able too roll on the medicine to areas but I feel that these haven't been treated properly and aren't healing. Areas need to be washed and irrigated, medicine applied and dry dressing applied to area daily' Meeting Attendees [employee N-case manager/registered nurse] ... [employee W-registered nurse] [employee J-LPN] [employee D-administrator]."</p> <p>A. On 2/19/15 at 4:15 PM, employee E (alternate administrator) indicated the case conference document suggests that the open areas were identified and the need to alter the plan of care should have been addressed but was not.</p> <p>B. On 2/19/15 at 3:15 PM, employee E indicated the skilled nurse should have addressed the wound with the physician on admission.</p> <p>3. On 2/19/15 3:15 PM, employee D (administrator) indicated staff are educated to report increased pain to the physician. The employee indicated being unable to locate documentation of the patient's baseline (tolerable) pain level.</p> <p>4. On 2/20/15 at 12:50 PM, during the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>interview with employee N (case manager / registered nurse), the employee indicated the patient started services 9/18/14 and upon initial assessment, a wound in the left axillary had been identified. The employee indicated, according to the patient, the wound was evaluated by the physician but no orders for treatment were given. Employee N indicated there was no communication with the physician regarding the evaluation of the wound. The employee indicated at the 11/14/14 recertification assessment, the wound was changed and had become 4 small wounds. The employee indicated being unable to locate documentation in the chart of physician notification of this and indicated being unable to locate documentation the chart evidencing a follow-up had been made. Employee N indicated the wounds had another change and the 4 wounds then become 2. The employee indicated being unable to locate documentation in the record to evidence physician notification. Employee N indicated at the 1/12/14 recertification assessment, the 2 wounds had become 1. The employee indicated on 1/19/15, a second wound on the patient's abdominal fold was discovered at which time the physician was notified and an appointment was scheduled for 1/21/15. Employee N indicated on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>1/21/15, the patient informed the employee of physician contact and of an appointment scheduled to a surgeon to address the wounds on 2/4/15. The employee indicated the patient was directed to go to the ER on 1/23/15 by the physician and have the abscess on the abdominal fold drained but failed to go and the employee indicated being unable to locate documentation in the clinical record of the physician's notification of this.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0484" states, "Communications policy and procedure: PURPOSE: To maintain effective communications to assure that all personnel providing services shall appropriately complement on another and support the objectives of the patient's care. POLICY: Communication regarding patient's care shall be documented in the clinical record. ... Field staff will communicate all pertinent information to nursing supervisor and/or nurse case manager of that patient's case. Nursing supervisors will review any new orders with or information with field staff for cases they are working on. The nursing supervisors will promptly alert the physician of any changes that suggest a need to alter the medical plan of care. ... The nursing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>supervisor will notify the patient's physician or other appropriate licensed professional staff and legal representatives, if any, of any significant physical or mental changes observed are reported by the patient."</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PHYSICIAN ORDERS" states, "PROCEDURE: ... 10. The agency will ensure that communication with the physician is timely, appropriate and consistent with the needs of the patient."</p> <p>Related to informing physician of changes in patient's condition.</p> <p>1. Clinical record #5 contained a plan of care for certification period 9/18 to 11/16/14 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>A. The record contained a document signed by employee N (registered nurse) on 9/18/14 titled "Comprehensive Adult</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Nursing Assessment" stating, "Date '09/18/14' Reason for Visit: Start of Care [checked] ... [page 6 of 20] INTEGUMENTARY STATUS ... Turgor Good Rash Dry Bruises Other (specify) 'redness under abd. [abdominal] folds, under left axilla' ... [page 9 of 20] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Left Axilla [axillary-arm pit]' Type: ... 'Open boil' Size (cm) [centimeter] (LxWxD) [length times width times depth] '1.2 cm x 1.6 cm' ... [page 16 of 20] CARE MANAGEMENT ... d. Medical Procedures/Treatments (e.g. changing wound dressing) 0 [checked] - No Assistance Needed in this Area ... [page 17 of 20] THERAPY AND PLAN OF CARE ... (M2250) Plan of Care Synopsis: ... Plan/Intervention a. Patient-Specific parameters for notifying physician of changes in vital signs or other clinical findings n/a [checked] Not applicable Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference ... Plan/Intervention e. Intervention(s) to monitor and mitigate pain 1 [checked] - Yes" The record failed to evidence the registered nurse addressed the wound with the physician.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>B. The record contained a document dated 10-20-14 by employee J [LPN-Licensed Practical Nurse] titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 10-20-14 ... Pain Rating '8/10' Pain Area 'arm pit' ... Note: 'med set up completed. Assessment and vs [vital signs] WNL [within normal limits]. Pt to go to ER [emergency room] for outpatient surgery for cyst under [left] arm. Rates pain 8/10 to that area. Discussed safety with transfers. The document failed to evidence the patients pain level (8 out of 10) or the patient's verbal report of outpatient surgery was addressed with the physician or case manager.</p> <p>C. The record contained a document dated 11-3-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-3-14 ... Pain Rating '7/10' Pain Area 'stomach' ... Note: 'med set up completed. Assessment and vs completed WNL. No edema noted. Rates stomach pain 7/10. underarm [left] has 4 holes Pt has medication BID to area. discussed using med as directed'" The record failed to evidence the LPN notified the physician or case manager of the patient's change in wound status and pain rating of 7/10.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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. The record contained a document dated 11-10-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-10-14 ... Note: 'Patient continues topical medication to wound in left axilla per MD order. Moderate serosanguineous drainage [with] odor. After pt. lifted [left] arm to put medicine on, moderate amount of dark blood, thick, from 4 areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>E. The record contained a document signed by employee N (registered nurse) on 11/14/14 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? Yes [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>movement: 3 [checked] - daily, but not constantly ... [page 5 of 14]</p> <p>INTEGUMENTARY STATUS (Cont'd)</p> <p>... WOUND CARE: (check all that apply) Wound care done during this visit: Yes [checked] Location(s) wound site: 'left axilla' ... Technique: Clean [checked] ... Patient tolerated procedure well: Yes [checked] ... [page 6 of 14]</p> <p>INTEGUMENTARY STATUS (Cont'd)</p> <p>Wound/Lesion #1 Location 'Proximal Left axilla' Type: 'abscess' Size: '0.6 x 0.5' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #2 Location '[left] axilla' Type: 'abscess' Size: '0.3 x 0.4' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #3 Location '[left] axilla' Type: 'abscess' Size: '0.4 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #4 Location 'lateral [left] axilla' Type: 'abscess' Size: '0.7 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]" The record failed to evidence the physician was made aware</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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 the patient's change in wound status at time of recertification.</p> <p>F. The record contained a document dated 11-24-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '11-24-14' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'Open areas to [left] axilla are now 2, was previously 4 smaller areas. Drainage noted, skin around pink. Pt complains of burning to areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>G. The record contained a document dated 12-8-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '12-8-14' ... Pain Rating '8/10' Pain Area 'Headache [Left] axilla ... Note: 'Pt. compliant [with] medications thru [through] previous week med set up. ... 1.5 cm x 3.1 cm x 0.2 cm deep [with] no tunneling. Serosanguineous drng [drainage] noted.'" The record failed to evidence the RN contacted the physician with the change in wound status and pain of 8 out of 10.</p> <p>H. The record contained a document dated 12-22-14 by employee J (LPN) titled "Nurse Care Visit Note" stating,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>"Patient Name [patient #5] Date 12-22-14 ... Pain Rating '9/10' Pain Area 'HA [headache]' ... SKIN WNL [checked] ... *Describe rash or wounds in note below including measurements. ... Note: 'med set up completed. Assessment and vs completed WNL. Rates HA 9/10. No edema noted BLE [bilateral lower extremities]. Discussed pt HA's and medication safety'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 9 out of 10.</p> <p>I. The record contained a document dated 1-5-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-5-15' ... Pain Rating 6/10 Pain Area 'back /[left] axilla' SKIN ... * Describe rash or wounds in note below including measurements ... Note: 'Pt compliant [with] meds through previous set up. Pt. tolerates visit well. Complains of headache and pain too back and left axilla wound. Wound has foul odor and drainage noted, MD aware.'" The record failed to evidence documentation of physician notification of wound status and pain rating.</p> <p>J. The record contained a document signed by employee N (registered nurse) on 1/12/15 titled</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>"RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? No Problem [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 2 [checked] - Less often than daily ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: No [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location '[Left] axilla' Type: 'abscess' Size (cm) (LxWxH [length times width times height]): '2.1 cm x 4.6 cm x 0.2 cm' Tunneling [zero] Stage [zero] Odor 'Y' Surrounding Skin 'Intact' Edema 'Y' ... Appearance of the wound bed 'Granulated red' Drainage/Amount Small [checked] Color Serosanguineous [checked] Consistency Thin [checked]" The record failed to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>K. The record contained a document dated 1-26-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-26-15' ... Pain Rating 7/10 Pain Area '[left] Ab [abdominal] fold ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... '[patient] reports MD called [patient] on 1-23-15 and told [patient] to go to the ER to have area on [left] [abdominal] fold drained but said [patient] didn't have a ride and today its too cold'" The record failed to evidence documentation of physician notification of the patient not reporting to the ER for the draining of the abscess.</p> <p>L. The record contained a document dated 2-2-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '2-2-15' ... Pain Rating '8/10' Pain Area 'Headache' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... 'Pt. tolerates visit well. ... Area has minimal drainage at this time [with] foul odor. Pt. c/o [complains of] tenderness to area. No s/s [signs and symptoms] of infection noted.'" The failed to evidence documentation of physician notification</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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 patient's pain level of 8 out of 10.</p> <p>M. The record contained a document dated 2/9/15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' Time in 4:40 p Time Out 5:00 PM ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Skin *describe rash or wounds in note below including measurements. ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The record failed to evidence the physician had been notified of the patient's pain rating of an 8 out of a 0-10 scale.</p> <p>N. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 7 out of 10.</p> <p>2. On 2/19/15 3:15 PM, employee D (administrator) indicated staff are educated to report increased pain to the physician. The employee indicated being unable to locate documentation of the patient's baseline (tolerable) pain level.</p> <p>3. On 2/20/15 at 12:45 PM, an interview with employee N (case manager/registered nurse) was conducted. The employee indicated the patient started services 9/18/14 and upon initial assessment, a wound in the left axillary had been identified. The employee indicated, according to the patient, the wound was evaluated by the physician but no orders for treatment were given. Employee N indicated there was no communication with the physician regarding the evaluation of the wound. The employee indicated at the 11/14/14 recertification assessment, the wound was changed and had become 4 small wounds. The employee indicated being unable to locate documentation in the chart of physician notification of this and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>indicated being unable to locate documentation the chart evidencing a follow-up had been made. Employee N indicated the wounds had another change and the 4 wounds then become 2. The employee indicated being unable to locate documentation in the record to evidence physician notification. Employee N indicated at the 1/12/14 recertification assessment, the 2 wounds had become 1. The employee indicated on 1/19/15, a second wound on the patient's abdominal fold was discovered at which time the physician was notified and an appointment was scheduled for 1/21/15. Employee N indicated on 1/21/15, the patient informed the employee of physician contact and of an appointment scheduled to a surgeon to address the wounds on 2/4/15. The employee indicated the patient was directed to go to the ER on 1/23/15 by the physician and have the abscess on the abdominal fold drained but failed to go and the employee indicated being unable to locate documentation in the clinical record of the physician's notification of this.</p> <p>4. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "Plan of Care" states, "POLICY: A written plan of care shall be developed for each client admitted to home care for skilled treatment in consultation with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>home health professional staff, the patient's physician, the patient and members of the patient's family.</p> <p>PURPOSE: 1. To ensure delivery of health care services that are medically required for the client. ... PROCEDURE: Plan of Treatment 1. Home health services are furnished to clients under the physician's certification that the services are medically required for the client. ... 2. The plan of care for each patient will include: ... All pertinent diagnoses ... 4. The forms: Oasis Start of Care (initial assessment), Patient medications, assessment summary, physician's orders and patient problem list constitute the Plan of Care and are submitted by the case manager and professional team members to the agency within 4 working days of the start of care date. ... 6. RN [registered nurse] case manager, therapists promptly inform the physician of any changes that suggest a need to alter the plan of care. 7. All changes in the plan of care are documented through written and signed physician orders."</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0484" states, "Communications policy and procedure: PURPOSE: To maintain effective communications to assure that all personnel providing services shall appropriately complement</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>on another and support the objectives of the patient's care. POLICY: Communication regarding patient's care shall be documented in the clinical record. ... Field staff will communicate all pertinent information to nursing supervisor and/or nurse case manager of that patient's case. Nursing supervisors will review any new orders with or information with field staff for cases they are working on. The nursing supervisors will promptly alert the physician of any changes that suggest a need to alter the medical plan of care. ... The nursing supervisor will notify the patient's physician or other appropriate licensed professional staff and legal representatives, if any, of any significant physical or mental changes observed are reported by the patient. ... "</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PHYSICIAN ORDERS" states, "POLICY: Every patient will have an individualized plan of care based on the medical, functional and psychosocial needs of each patient. Home care staff shall administer care and treatment according to the specific individualized instructions of the patient;s designated primary physician. ... PURPOSE: ... 2. To facilitate quality improvement in the receipt of physician orders. ...</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 226 Bldg. 00	<p>PROCEDURE: 1. Physician orders are initiated when physician or referral source requests skilled services, and required prior any care is initiated, either verbally or in writing. ... 3. Physician verbal or telephone orders for care are recorded and verified by appropriate qualified and licensed professional staff members. ... A. The physician will be notified immediately of any changes in the patient's condition which indicate changes to the plan of treatment. ... Medical Supervision ... 10. The agency will ensure that communication with the physician is timely, appropriate and consistent with the needs of the patient. ...</p> <p>."</p> <p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The duties of a home health aide include the provision of hands on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self administered. Based on clinical record review, personnel file review, observation and interview, the agency failed to ensure the home health aide did not administer a</p>	G 226	Policy created to provide specific scope of practices for Home Health Aides. Copy of policy: Scott's Home Healthcare LLC	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>prescription medication in 1 of 2 home visits of home health aides observations creating the potential to affect all patients of the agency receiving home health aide services. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained a plan of care for certification period 9/18 to 11/16/14 stating, "21. Orders for Discipline and Treatments ... HHA [home health aide]: 6 hr/day [hours per day] x 7 d/wk [days per week] x 60 days per medicaid PA to assist with all ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan"</p> <p>The record contained a document titled "HOME HEALTH AIDE CARE PLAN" with a date of review by employee N (registered nurse/case manager) on 1-12-15 to include foot care daily as an assigned task.</p> <p>A. On 2/19/15 at 10:15 AM, a home visit was conducted with patient #5 to observe care being provided by the home health aide (employee Z). At 10:45 AM, employee Z was asked about the task of providing foot care. The employee indicated after assistance with showering, the employee rubs a cream on</p>		<p>Job Title: Home Health Aide Effective: 3-30-15</p> <p>No: 606.00</p> <p>Reviewed:</p> <p>Direct Report: RN Case Manager Revised:</p> <p>"Primary Purpose: The primary purpose of your job position is to provide high quality home health aide services within the home health aide scope of practice to assigned patients in their place of residence with our established policies and procedures, and as may be directed by your RN supervisor.</p> <p>Performance Responsibilities According to Home Health Aide</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>the patient's feet. The employee presented the cream to the surveyor at which time it was observed to be a prescription medication of Econazole Nitrate 1% cream, a topical antifungal medication. The employee indicated the cream is put on the feet, but not in between the toes, and then the employee will place the patient's socks on "to keep it all in." The employee indicated someone in the office had told her to perform this task about a month ago but could not remember the staff member who told this to her.</p> <p>B. On 2/20/15 at 12:45 PM, an interview was conducted with employee N (registered nurse/ case manager). The employee indicated never seeing the Econazole Nitrate 1% cream in the patient's home before and indicated the patient never told of use of this medication. The employee indicated sending a fax to the patient's primary physician on 2/19/15 requesting information on the cream. The employee indicated the cream is to be used BID for rashes. The employee indicated not providing instructions to the home health aide to perform this task.</p> <p>2. Personnel file Z contained a job description signed and dated by the employee on 3/10/14 titled "Home Health</p>		<p>Scope of Practice:</p> <p>A. Patient Care</p> <p>1.Performs personal care activities contained in a written assignment by the Case Manager which includes: Personal hygiene, assisting with ambulation, oral care, skin care, hair care, cooking, feeding, dressing, shaving, vital signs and nail care.</p> <p>1.Assists with/Reminds of Medications – limited to opening and closing a medication container, returning a medication to the proper storage area and assisting in reordering medications from a pharmacy. Home Health aides are not to administer medications including applying prescription creams or powders but may assist patient as needed and as included on home health aide careplan.</p> <p>2.Follows a written plan of care, which includes realistic goals and interventions, which is prepared by the case manager.</p> <p>3.Performs assigned activities that are taught by an RN.</p> <p>4.Responds to patient needs in a timely manner.</p> <p>5.Provides care in a cost effective manner.</p> <p>6.Treats all patients with kindness and respect</p> <p>7.Completes housekeeping tasks as</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
	Aide" stating, "Performance Responsibilities: A. Patient Care 1. Performs personal care activities contained in a written assignment by the Case Manager which includes: Personal hygiene, assisting with ambulation, ... 2. Assists in the administration of medication - limited to opening and closing a medication container, returning a medication to the proper storage area"		written and directed on the plan of care..." This policy states that Home Health Aides are not to give any medications to patients. Home Health Aides are allowed, if care plan states, to provide medication reminders to patient. No Home Health Aide will provide any topical application of prescription cream and will follow counseling/disciplinary procedure as needed for violation. Communication Form created to be utilized by scheduling employees and completed on every phone call taken regarding home health aide or patient. Once concern is documented, RN to be notified immediately to inform of situation. RN to instruct on resolution if scheduling can complete. Patient to be called back and documentation completed on every concern or request. Once resolution is completed and RN has signed and documented, all completed forms to be delivered to Administrator for review and filing. Communication form to be filed in patient chart, Correspondence and Misc tab, to ensure continuity of care and show communication between scheduling, nursing, and patient. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 235 Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure the clinical record contained appropriately authenticated clinical notes in 1 of 10 clinical records reviewed creating the potential to affect all 107 of the agency's patients (See G 236).</p> <p>The cumulative effect of this systemic problem resulted in the agency's inability to meet the requirements of the Condition of Participation 484.48 Clinical Record.</p>	G 235	<p>recurring in the future.</p> <p>Appropriate staff to be in serviced on the following: All Home Health Aide Daily Notes will be completed in entirety by Home health Aide completing visit. Home Health Aide is required to mark appropriately boxes indicating patient care completed and sign document under Employee Signature. Patient or documented authorized signature is to sign under Patient Signature. In the case evidence is found to have missing information of any kind on Home Health Aide Daily note, Scheduler will contact Home Health Aide during current business day, who will be required to come in to office and complete note. If patient signature is missing Home Health Aide will be required to retrieve note, deliver to patient for signature and date, and return to office within 24 hours of notification. Auditor employee to audit charts for note accuracy monthly. Disciplinary action including write up and counseling by HR employee to be properly enforced if Home Health Aide has a repeat offense. Administrator to be notified by Schedulers of any corrective action taken and upon completion through communication form. Mandatory In service to be completed by</p>	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
G 236 Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the clinical record contained appropriately authenticated clinical notes in 1 of 10 clinical records reviewed creating the potential to affect all 107 of the agency's patients. (#4)</p> <p>Findings include:</p> <p>1 . Clinical record #4, start of care 6/19/14 and discharge date 8/9/14, evidenced a plan of care for certification</p>	G 236	<p>every Home health Aide on proper Home Health Aide Daily note completion. HR to track attendance of mandatory in service to ensure compliance. Administrator to ensure compliance is maintained by meeting with Auditor employee monthly to review any corrections made in order to educate staff on patterns that are seen.</p> <p>All Home Health Aide Daily Notes will be completed in entirety by Home Health Aide completing patient visit. Home health aides will complete hha notes according to the policy titled Home Health Aide Note Completion, Auditing, and Correction Policy which states: Policy: Home Health Aide staff will properly complete documentation according to accepted professional standards and principles that apply to home health documentation . All documentation is to be properly</p>	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>period 6/20 to 8/18/14 with orders for home health aide services 12 hours per day, 7 days per week for 60 days. The record contained a physicians order for home health aide services 8 hours per day, 7 days per week.</p> <p>2. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee DD-home health aide] Date 6/24/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Partial bed bath [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... Feeds Self [checked] Encourage Fluids [checked] ACTIVITY LEVEL Up with Assistance [checked] W/C [wheelchair] [checked] Partial Weight Bearing [checked] ... Transfer bed/chair [checked] Transfer toilet [checked] ... ELIMINATION Continent [checked] ... Bedside Commode [checked] ... OTHER ... Medication Reminder [checked] ... HOME MAKING ... Dishes [checked] ... Other: [checked] ... Employee's Signature [employee DD] Date: '6/24/14' Patient's Signature [name of patient #4] / [signature of employee E-alternate administrator/Director of nursing] Date '6/24/14'."</p>		<p>authenticated by the staff member who completes the work <u>only</u> and patient's will sign home health aide documentation confirming that the clock in and out times, the date, and the checked off tasks were completed on that date between those times according to the plan of care. Procedure: Note Completion- 1. When arriving at patient home, HHA will locate company folder and check careplan for tasks to be completed. 2. Next, HHA will document time of arrival at patient home on nurse aide note on appropriate time. This should be the time HHA was scheduled to be there on his or her calendar. 3. Complete tasks and check them off on note as completed according to the home health aide careplan. Only tasks which have been checked off on hha careplan by the Registered Nurse Supervisor or state "prn" in check box should be addressed/completed at this visit and documented on this note. 4. When visit time comes to end per hha schedule, aide should document end time in appropriate line on hha note and sign on hha signature line and date line next to it. When signing aide is confirming he/she completed the tasks checked as being completed on that date between the in and out time documented and confirming these were completed in accordance with the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>3. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee EE-home health aide] Date 7/4/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Complete bed bath [checked] Assist-Shower [checked] ... Shampoo Hair [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... HOMEMAKING Light housekeeping [checked] ... Dishes [checked] ... Make bed [checked] Trash [checked] Dusting [checked] Sweeping [checked] ... Employee's Signature [employee E] Date: '7/4/14' Patient's Signature [employee E] Date '7/4/14'."</p> <p>4. On 2/18/15 at 3 PM, employee E indicated the patient had orders for home health aide services 8 hours per day, 7 days per week and the aide frequency was 2 times per day, 4 hours per visit. The employee indicated he/she reviews the aide's documentation of the visit and if something is wrong with the document, he/she corrects it. The employee indicated the 7/4/14 aide visit was performed by employee EE but there must have been something wrong with the aides documentation because employee E had to re-write it. Employee E stated, "I did not make the visit, [name</p>		<p>HHA careplan. 5. The hha should then request for the patient/or patient family to sign his/her own name on the patient/family signature line and remind them that by doing so they are confirming that the aide was at their home, between the documented times and completed the checked off tasks that were completed in accordance with the hha careplan that the patient was active in helping develop for his/her own care. The patient should also document the date on the date line next to his/her signature. Auditing and Corrections of HHA note- 1. Kokomo HHAs are to turn their notes in each day after their visits are complete. There is a drop box located at the front door of the office building in kokomo. In areas other than Kokomo, a courier is assigned to pick up notes and HHA will be oriented to this when beginning employment. 2. When HHAs turn in notes, they will first be verified in the computer program for time, date and completion of visit. If notes do not match schedule, a copy will be made and forwarded to HR for counseling of scheduler and home health aide. 3. Notes will be audited before filed into the patient record for correctness including: completion in black ink only, tasks completed compared to HHA careplan, and confirmation signatures. Auditor nor anyone in the office will make</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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 employee EE] did but there must have been something wrong with the document so I re-did it." Employee E indicated he/she should have wrote employee EE's name where the document states, "Employee's Signature." The employee indicated being unsure of how many times this has occurred.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "CLINICAL RECORDS -PURPOSE AND CONTENT" state, "PROCEDURE: Records are documented using professional standards and will contain the following: ... 7. Signed and dated clinical notes for each contact which are written the day of service and incorporated into the patient's clinical record at least weekly."</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0608" states, "POLICY: Clinical chart order and closed chart order and retention. ... The clinical record will contain pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows. ... All entries must be legible, clear, complete and appropriately authenticated and dated. Authentications must include signatures or a secured computer entry. ...</p>		<p>any type of alteration on the home health aide note. If notes do not match careplan, are in another color of ink a copy will be made and the copy will be sent to HR for counseling of home health aide. If a signature is missing, the note will be given to the scheduler, the scheduler will contact the home health aide, and the home health aide will be required to get the proper signatures to authenticate the note within 24 hours or a copy will be made of the note and giving to HR for counseling/disciplinary service and visit for that note will not be billed. 4. If a home health aide writes the wrong information down during a visit and realizes it during the visit, he or she is to put one line through the incorrect information, write "error" above it, and include date, time and their initials. If these are not completed correctly, auditor will again make a copy of the note and send to HR for HHA counseling. HR to track disciplinary form on employees. Mandatory In Service to be completed by every Home health Aide on proper home health aide daily note completion. The Administrator oversees the nurse management staff and has inserviced the Nursing Supervisor/Alt Administrator and all nurse management staff on the HHA note completion policy and has instructed them that immediate termination would be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
N 000 Bldg. 00	<p>"</p> <p>This visit was for a state home health relicensure survey.</p> <p>Survey Dates: February 18, 19, 20, and 23, 2015.</p> <p>Facility #: 12928</p> <p>Medicaid #: 201091400</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p>	N 000	<p>the consequence of violating this policy. HR to track all attendance of mandatory in service to ensure all appropriate staff present. Administrator to instruct in service and provide documented minutes. HR employees to keep all in service tracking documentation and provide upon request. HR to discipline through write up process, any staff that does not complete in service. Non compliant Home Health Aides will not be given scheduled patient visit hours until mandatory in service information has been received. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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	
N 470 Bldg. 00	<p>March 24, 2015</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on agency policy review and observation and interview, the agency failed to ensure staff followed infection control practices for 1 of 5 home visit observations. (#5)</p> <p>Findings include:</p> <p>1. During a home visit observation on 2/19/15 at 11 AM, employee J (licensed practical nurse), was observed providing wound care to patient #5. After donning clean gloves, employee J prepped a table with the wound care supplies, cleansed the wound with normal saline on a gauze pad and then placed the pad in a trash bag, applied Aquacel Ag wound pad inside the wound, covered with a sterile gauze pad, applied tape to secure, removed gloves and placed in trash bag, and then washed hands with soap and water.</p> <p>2. The agency policy with an effective</p>	N 470	<p>All clinical staff will be required to attend an in service and skills check off regarding proper infection control procedures. All staff hired by the HHA will be required to perform a competency skills check off on proper infection control procedures. All clinical staff will be required to attend and complete a yearly in service including a skills check off to ensure proper infection control practices are being performed. HR staff to document and track in service and skills check off. Administrator to receive copy of completion as follow up.</p>	03/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>date of 7/20/12 and a reviewed date as 7/25/14 titled "INFECTION CONTROL" states, "POLICY: All home care staff will follow established infection control procedures. PURPOSE: To provide measures to prevent exposures to infectious diseases during the treatment of patients. PROCEDURE: Standard Precautions/Universal Precautions 1. Standard Precautions are routine barrier precautions that are utilized with all patients to protect employees from contact with blood and body fluids, secretions, excretions, non-intact skin, and mucous membranes. ... 4. Staff should wash their hands before and after patient contact, upon removal of gloves, before and after invasive procedures, after handling soiled or contaminated materials, ... and as needed. 5. Medical gloves should be worn when: a) contact with blood or body fluids is likely; b) providing care to non-intact skin; c) handling or cleaning contaminated equipment ... 6. Gloves should be changed between patient contact and procedures. Hands should be washed thoroughly after removal of gloves. ... "</p> <p>3. The agency policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "INFECTION CONTROL-HAND WASHING" states, "POLICY: All health care workers shall</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
N 484 Bldg. 00	<p>wash their hands frequently and appropriately. ... Health care workers shall wash hands: ... 4. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes,"</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record review, observation, policy review, and interview, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively in 1 of 7 active patients reviewed creating the potential to affect all patients of the agency. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained a plan of care for certification period 9/18 to 11/16/14 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of</p>	N 484	All appropriate staff will be in serviced on the following: RN will utilize Coordination of Care form created to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visits. RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>A. The record contained a document signed by employee N (registered nurse) on 9/18/14 titled "Comprehensive Adult Nursing Assessment" stating, "Date '09/18/14' Reason for Visit: Start of Care [checked] ... [page 6 of 20] INTEGUMENTARY STATUS ... Turgor Good Rash Dry Bruises Other (specify) 'redness under abd. [abdominal] folds, under left axilla' ... [page 9 of 20] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Left Axilla [axillary-arm pit]' Type: ... 'Open boil' Size (cm) [centimeter] (LxWxD) [length times width times depth] '1.2 cm x 1.6 cm' ... [page 16 of 20] CARE MANAGEMENT ... d. Medical Procedures/Treatments (e.g. changing wound dressing) 0 [checked] - No Assistance Needed in this Area ... [page 17 of 20] THERAPY AND PLAN OF CARE ... (M2250) Plan of Care Synopsis: ... Plan/Intervention a. Patient-Specific parameters for notifying physician of changes in vital signs or other clinical findings n/a [checked] Not applicable Physician has chosen not to establish patient-specific parameters for this patient. Agency will use</p>		<p>communicate all auditing completed monthly along with revisions made. Policy on pain protocols created to provide proper procedure on identifying pain and addressing with MD for resolution. RN to establish baseline pain upon admission with patient. RN to document in patient assessment document and on 485 assessment. RN to address pain at each nurse visit and supervisory visit. RN to notify MD of any pain identified outside of baseline. RN to document any instructions from MD on resolution of symptoms. RN to notify patient and implement instructions given with patient. RN to document in clinical chart notification and instructions to patient and any/all follow up to ensure resolution. ADON to review all clinical notes written by RN to ensure proper procedures are followed and documentation completed appropriately. Administrator to ensure procedure is being followed and compliance is maintained. RN will utilize Coordination of Care form created to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visits. RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>standardized clinical guidelines accessible for all care providers to reference ... Plan/Intervention e. Intervention(s) to monitor and mitigate pain 1 [checked] - Yes" The record failed to evidence the registered nurse addressed the wound with the physician.</p> <p>B. The record contained a document dated 10-14-14 by employee N titled "HHA Supervisory Visit" stating, "Patient Name [patient #5] Date of visit '10-14-14' ... Please list any patient concerns and/or HHA training you feel is needed '[left] armpit - now 3 open areas where draining large amount serosanguineous, slight odor, skin around red'"</p> <p>A document titled "CLINICAL NOTE" states, "10-14-14 During a sup visit nurse asked pt how area under [patients] left axilla was doing and [patient] stated it had been draining even more. Nurse assessed area and pt now has 3 open areas to left axilla that are still draining large amounts of serosanguineous drainage [with] slight odor. skin surround is read and patient reports that [patient's] left arm hurts at times. Nurse call MD office while in home and scheduled appt [appointment] for Friday Oct [October] 17th at 11:30 AM to have the area evaluated. [employee</p>		<p>document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made. Medication Profile will be reviewed at every patient visit including supervisory visits, skilled nursing visits, recertification and any assessment per MD order. ADON to review all completed visit/assessment documentation. Monthly audits to be completed to ensure medication review was completed on each patient during visits. Patient letter given to every patient upon admission stating patient to inform RN by calling office if any changes in medications occur between scheduled visits. If medication changes occur, RN will add medication to Medication Profile in patient home and clinical chart. RN will notify MD to verify change and document in clinical note. ADON will review all clinical documentation and monitor any follow up needed. Administrator will meet daily with ADON to ensure RN has followed up and resolution/documentation is complete. Policy created to provide specific scope of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>N-registered nurse]." The record failed to evidence the registered nurse followed-up on the patient's 10/17/14 visit with the physician.</p> <p>C. The record contained a document dated 10-20-14 by employee J [LPN-Licensed Practical Nurse] titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 10-20-14 ... Pain Rating '8/10' Pain Area 'arm pit' ... Note: 'med set up completed. Assessment and vs [vital signs] WNL [within normal limits]. Pt to go to ER [emergency room] for outpatient surgery for cyst under [left] arm. Rates pain 8/10 to that area. Discussed safety with transfers. The document failed to evidence the patients pain level (8 out of 10) or the patient's verbal report of outpatient surgery was addressed with the physician or case manager.</p> <p>D. The record contained a document dated 11-3-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-3-14 ... Pain Rating '7/10' Pain Area 'stomach' ... Note: 'med set up completed. Assessment and vs completed WNL. No edema noted. Rates stomach pain 7/10. underarm [left] has 4 holes Pt has medication BID to area. discussed using med as directed'" The record failed to</p>		<p>practices for Home Health Aides. Copy of policy: Scott's Home Healthcare LLC</p> <p>Job Title: Home Health Aide Effective: 3-30-15 No: 606.00</p> <p>Reviewed: Direct Report: RN Case Manager Revised:</p> <p>"Primary Purpose: The primary purpose of your job position is to provide high quality home health aide services within the home health aide scope of practice to assigned patients in their place of residence with our established policies and procedures, and as may be directed by your RN supervisor.</p> <p>Performance Responsibilities According to Home Health Aide Scope of Practice:</p> <p>A. Patient Care</p> <p>1. Performs personal care activities contained in a written assignment by the Case Manager which includes: Personal hygiene, assisting with ambulation, oral care, skin care, hair care, cooking, feeding, dressing,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>evidence the LPN notified the physician or case manager of the patient's change in wound status and pain rating of 7/10.</p> <p>E. The record contained a document dated 11-10-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-10-14 ... Note: 'Patient continues topical medication to wound in left axilla per MD order. Moderate serosanguineous drainage [with] odor. After pt. lifted [left] arm to put medicine on, moderate amount of dark blood, thick, from 4 areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>F. The record contained a plan of care for certification period 11/17/15 to 1/15/15 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>G. The record contained a document signed by employee N (registered nurse) on 11/14/14 titled "RECERTIFICATION/FOLLOW-UP</p>		<p>shaving, vital signs and nail care.</p> <ol style="list-style-type: none"> 1. Assists with/Reminds of Medications – limited to opening and closing a medication container, returning a medication to the proper storage area and assisting in reordering medications from a pharmacy. Home Health aides are not to administer medications including applying prescription creams or powders but may assist patient as needed and as included on home health aide careplan. 2. Follows a written plan of care, which includes realistic goals and interventions, which is prepared by the case manager. 3. Performs assigned activities that are taught by an RN. 4. Responds to patient needs in a timely manner. 5. Provides care in a cost effective manner. 6. Treats all patients with kindness and respect 7. Completes housekeeping tasks as written and directed on the plan of care..." <p>This policy states that Home Health Aides are not to give any medications to patients. Home Health Aides are allowed, if care plan states, to provide medication reminders to patient. No Home Health Aide will provide any topical application of prescription cream and will follow counseling/disciplinary procedure as needed for violation. The Administrator will be responsible</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? Yes [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 3 [checked] - daily, but not constantly ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: Yes [checked] Location(s) wound site: 'left axilla' ... Technique: Clean [checked] ... Patient tolerated procedure well: Yes [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Proximal Left axilla' Type: 'abscess' Size: '0.6 x 0.5' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #2 Location '[left] axilla' Type: 'abscess' Size: '0.3 x 0.4' Odor 'Y' Surrounding</p>		for completing the correction of this deficiency and preventing this deficiency from recurring in the future.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #3 Location '[left] axilla' Type: 'abscess' Size: '0.4 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #4 Location 'lateral [left] axilla' Type: 'abscess' Size: '0.7 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>H. The record contained a document dated 11-24-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '11-24-14' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'Open areas to [left] axilla are now 2, was previously 4 smaller areas. Drainage noted, skin around pink. Pt complains of burning to areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>I. The record contained a document</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>dated 12-8-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '12-8-14' ... Pain Rating '8/10' Pain Area 'Headache [Left] axilla ... Note: 'Pt. compliant [with] medications thru [through] previous week med set up. ... 1.5 cm x 3.1 cm x 0.2 cm deep [with] no tunneling. Serosanguineous drng [drainage] noted.'" The record failed to evidence the RN contacted the physician with the change in wound status and pain of 8 out of 10.</p> <p>J. The record contained a document dated 12-22-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 12-22-14 ... Pain Rating '9/10' Pain Area 'HA [headache]' ... SKIN WNL [checked] ... *Describe rash or wounds in note below including measurements. ... Note: 'med set up completed. Assessment and vs completed WNL. Rates HA 9/10. No edema noted BLE [bilateral lower extremities]. Discussed pt HA's and medication safety'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 9 out of 10.</p> <p>K. The record contained a document dated 1-5-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-5-15' ... Pain Rating</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>6/10 Pain Area 'back /[left] axilla' SKIN ... * Describe rash or wounds in note below including measurements ... Note: 'Pt compliant [with] meds through previous set up. Pt. tolerates visit well. Complains of headache and pain too back and left axilla wound. Wound has foul odor and drainage noted, MD aware.' ... "</p> <p>The record failed to evidence documentation of physician notification of wound status and pain rating.</p> <p>L. The record contained a plan of care signed by the attending physician on 1/15/15 for certification period 1/16/15 to 3/16/15 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>M. The record contained a document signed by employee N (registered nurse) on 1/12/15 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? No Problem [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 2 [checked] - Less often than daily ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: No [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location '[Left] axilla' Type: 'abscess' Size (cm) (LxWxH [length times width times height]): '2.1 cm x 4.6 cm x 0.2 cm' Tunneling [zero] Stage [zero] Odor 'Y' Surrounding Skin 'Intact' Edema 'Y' ... Appearance of the wound bed 'Granulated red' Drainage/Amount Small [checked] Color Serosanguineous [checked] Consistency Thin [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>N. The record contained a document dated 1-26-15 by employee N titled</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>"Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-26-15' ... Pain Rating 7/10 Pain Area '[left] Ab [abdominal] fold ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... '[patient] reports MD called [patient] on 1-23-15 and told [patient] to go to the ER to have area on [left] [abdominal] fold drained but said [patient] didn't have a ride and today its too cold'" The record failed to evidence documentation of physician notification of the patient not reporting to the ER for the draining of the abscess.</p> <p>O. The record contained a document dated 2-2-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '2-2-15' ... Pain Rating '8/10' Pain Area 'Headache' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... 'Pt. tolerates visit well. ... Area has minimal drainage at this time [with] foul odor. Pt. c/o [complains of] tenderness to area. No s/s [signs and symptoms] of infection noted.'" The record failed to evidenced the RN assessed the wounds (to include measurements), failed to evidence the patient's pain level was addressed, and failed to evidence documentation of physician notification of patient's pain level of 8 out of 10.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>P. The record contained a document dated 2/9/15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' Time in 4:40 p Time Out 5:00 PM ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Skin *describe rash or wounds in note below including measurements. ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The document failed to evidence the RN had provided wound assessment to include measurements. The record failed to evidence the physician had been notified of the patient's pain rating of an 8 out of a 0-10 scale.</p> <p>A document titled "CLINICAL NOTE" states, "2-10-15 Pt called et [and] stated [patient] hasn't received [patient's] supplies for wound care. Pt concerned about when wound care will start. Call [physician] at St. Joseph Wound Center to see if staff has ordered supplies. [employee K]."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Q. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the case manager of the pain level of 7 out of 10 and failed to evidence the LPN assessed the abdominal fold abscess.</p> <p>R. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 7</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>out of 10.</p> <p>S. The record contained a document titled "HOME HEALTH AIDE CARE PLAN" with a date of review by employee N (registered nurse/case manager) on 1-12-15 to include foot care daily as an assigned task.</p> <p>1.) On 2/19/15 at 10:15 AM, a home visit was conducted with patient #5 to observe care being provided by the home health aide (employee Z). At 10:45 AM, employee Z was asked about the task of providing foot care. The employee indicated after assistance with showering, the employee rubs a cream on the patient's feet. The employee presented the cream to the surveyor at which time it was observed to be a prescription medication of Econazole Nitrate 1% cream, a topical antifungal medication. The employee indicated the cream is put on the feet, but not in between the toes, and then the employee will place the patient's socks on "to keep it all in." The employee indicated someone in the office had told her to perform this task about a month ago but could not remember the staff member who told this to her.</p> <p>The record contained a document titled "MEDICATION</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>PROFILE" with a review date of 2/11/15 by employee N (registered nurse/case manager). The document failed to list Econazole Nitrate 1% cream as a current medication used by the patient.</p> <p>2.) On 2/19/15 at 10:55 AM, during the home visit with patient #5, an interview was conducted with employee J (licensed practical nurse) who was present for a scheduled skilled nursing visit. The employee indicated the Econazole Nitrate 1% cream was listed on the medication profile as Cleocin T 1% (a topical antibiotic) and is to be applied to the left axillary wound two times per day. The employee indicated the Cleocin T 1% cream was prescribed on 10/29/14. The employee stated, "This is to be under [patient's] arm, not on her feet."</p> <p>3.) On 2/19/15 at 11:05 AM, during the home visit with patient #5, the patient indicated using the Econazole Nitrate 1% cream on his/her feet for a while and it was being used before the wound appeared under the left axillary. The patient indicated the doctor prescribed this to be used on his/her feet and legs.</p> <p>4.) On 2/19/15 at 11:10 AM, during the home visit with patient #5,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>employee J (licensed practical nurse) notified employee N (registered nurse/case manager) via telephone. Employee J discussed with employee N the use by the patient of the Econazole Nitrate 1% cream and employee J stated to employee N, "On new med sheet, I couldn't find it, the one [medication profile sheet] that you sent, because we got the Eucerin Cream to [patient's] feet and legs. It is on the old one [medication profile sheet] that was here. You have it written as Cleosin, left axillary BID [two times per day] but its not [listed] on the new one [medication profile sheet]." The patient then stated, "I have been using that on my feet and legs before I ever had a hole [wound in left axilla]." The patient indicated is was prescribed by the doctor because of bumps on his/her legs that kept "busting open." Employee J ended the call with employee N and indicated the RN (employee N) would have to clarify the Econazole Nitrate 1% cream with the physician because the RN (employee N) was not aware of the patient having that medication.</p> <p>5.) On 2/20/15 at 12:45 PM, an interview was conducted with employee N (registered nurse/ case manager). The employee indicated never seeing the Econazole Nitrate 1% cream in the patient's home before and indicated the</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>patient never told of use this medication. The employee indicated sending a fax to the patient's primary physician on 2/19/15 requesting information on the cream. The employee indicated the cream is to be used BID for rashes. The employee indicated not providing instructions to the home health aide to perform this task.</p> <p>2. A document dated 11/14/14 titled "CASE CONFERENCE" states, "Patient Name [patient #5] Date '11-14-14' Summary of meeting: 'Patient has had abscess under left axilla for few months now. Area had opened and MD was notified. Pt seen MD and referred to surgeon. The surgeon opted for no surgery and gave [patient] medicine to apply daily to area. The wound site is now 4 open holes and [patient] has large dark drainage from areas daily. Pt is able too roll on the medicine to areas but I feel that these haven't been treated properly and aren't healing. Areas need to be washed and irrigated, medicine applied and dry dressing applied to area daily' Meeting Attendees [employee N-case manager/registered nurse] ... [employee W-registered nurse] [employee J-LPN] [employee D-administrator]."</p> <p>A. On 2/19/15 at 4:15 PM, employee E (alternate administrator) indicated the case conference document suggests that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>the open areas were identified and the need to alter the plan of care should have been addressed but was not.</p> <p>B. On 2/19/15 at 3:15 PM, employee E indicated the skilled nurse should have addressed the wound with the physician on admission.</p> <p>3. On 2/19/15 3:15 PM, employee D (administrator) indicated staff are educated to report increased pain to the physician. The employee indicated being unable to locate documentation of the patient's baseline (tolerable) pain level.</p> <p>4. On 2/20/15 at 12:50 PM, during the interview with employee N (case manager / registered nurse), the employee indicated the patient started services 9/18/14 and upon initial assessment, a wound in the left axillary had been identified. The employee indicated, according to the patient, the wound was evaluated by the physician but no orders for treatment were given. Employee N indicated there was no communication with the physician regarding the evaluation of the wound. The employee indicated at the 11/14/14 recertification assessment, the wound was changed and had become 4 small wounds. The employee indicated being unable to locate documentation in the chart of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>physician notification of this and indicated being unable to locate documentation the chart evidencing a follow-up had been made. Employee N indicated the wounds had another change and the 4 wounds then become 2. The employee indicated being unable to locate documentation in the record to evidence physician notification. Employee N indicated at the 1/12/14 recertification assessment, the 2 wounds had become 1. The employee indicated on 1/19/15, a second wound on the patient's abdominal fold was discovered at which time the physician was notified and an appointment was scheduled for 1/21/15. Employee N indicated on 1/21/15, the patient informed the employee of physician contact and of an appointment scheduled to a surgeon to address the wounds on 2/4/15. The employee indicated the patient was directed to go to the ER on 1/23/15 by the physician and have the abscess on the abdominal fold drained but failed to go and the employee indicated being unable to locate documentation in the clinical record of the physician's notification of this.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0484" states, "Communications policy and procedure: PURPOSE: To</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>maintain effective communications to assure that all personnel providing services shall appropriately complement on another and support the objectives of the patient's care. POLICY: Communication regarding patient's care shall be documented in the clinical record. ... Field staff will communicate all pertinent information to nursing supervisor and/or nurse case manager of that patient's case. Nursing supervisors will review any new orders with or information with field staff for cases they are working on. The nursing supervisors will promptly alert the physician of any changes that suggest a need to alter the medical plan of care. ... The nursing supervisor will notify the patient's physician or other appropriate licensed professional staff and legal representatives, if any, of any significant physical or mental changes observed are reported by the patient. ... "</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PHYSICIAN ORDERS" states, "PROCEDURE: ... 10. The agency will ensure that communication with the physician is timely, appropriate and consistent with the needs of the patient. ... "</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
N 504 Bldg. 00	<p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the patient was informed, in advance, of any changes in the care to be furnished in 3 of 7 active patient records reviewed creating the potential to affect all 107 of the agency's patients. (#2, #5, and #10)</p> <p>Findings include:</p> <p>1. Clinical record #2 contained a physicians plan of care for certification period 12/2/14 to 1/30/15 with orders to include home health aide services 1 hour per day, 7 days per week for 60 days. The record failed to evidence home</p>	N 504	All appropriate staff will be in serviced on the following: Missed Visit Note revised to state date and time patient was notified of inability to fill visit, all applicable staff notified to attempt to fill visit, date and time MD was notified of missed visit, person assuming care for patient, and RN signature. Scheduling employees to complete Missed Visit Note immediately upon cancellation by patient or home health agency and contact patient to make alternate plans for coverage. Daily huddles to be completed with each member of scheduling, case management, Administrator, and HR every morning. At this time weekly schedules to be reviewed indicating any unfilled visits, concerns, and missed visits	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>health aide services were conducted on 1/10/15 and 1/11/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/24/15, signed by employee BB (home health aide), titled "Home Health Aide Daily Note." The document states, "Time In 10:00 am Time Out 11:00 am."</p> <p>B. The record evidenced a document dated 1/25/15, signed by employee BB, titled "Home Health Aide Daily Note." The document states, "Time In 10:00 am Time Out 11:00 am."</p> <p>C. On 2/20/15 at 9 AM, a home visit was conducted with patient #2. The patient indicated the home health aide is supposed to come at 9 AM every day for 1 hour. The patient indicated a few times the aide came at 10 AM instead of 9 AM and indicated not being notified of the change in arrival time. The patient indicated not having an aide for the dates of Saturday, 1/10/15 and Sunday, 1/11/15 and on 1/10/15, the patient contacted the office and spoke with employee CC (office staff) who reassured patient that an aide would arrive on 1/11/15. The patient indicated the aide failed to arrive again on 1/11/15 at which time the patient contacted the office and</p>		<p>that need addressed due to absences by Home Health Aides. Daily huddle form to be utilized to ensure these topics are addressed. Assistant to administrator to collect all forms and type up summary for Administrator. Administrator to ensure resolution occurs and compliance maintained on all unfilled visits or concerns covered in daily huddle by end of business day. Policy created to ensure consistent patient scheduling visit times. Rn to request and discuss time frame at admission for scheduling home health visits with patient of record. Once admission is complete, RN to call in admission information to ADON who will take completed information to appropriate scheduling employee to initiate scheduling of patient home health services. As per the information given at admission, the assigned scheduler will coordinate with the patient to ensure the home health visits are scheduled at the patient requested time and will be maintained at that time unless requested otherwise by the patient. In the instance an employee cannot fulfill the scheduled home health visit, the assigned scheduler will make every attempt to find an alternative home health aide to complete the patient's scheduled visit. The patient will maintain communication with the assigned scheduler regarding this process</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>spoke to employee CC and was told the employee would "Look into it." The patient indicated not being contacted back from the agency.</p> <p>D. On 2/23/15 at 12:35 PM, employee E (alternate director of nursing) indicated it is the responsibility of the on-call staff to contact the patient and inform them of any changes or time differences for the scheduled visit.</p> <p>2. Clinical record #5 contained a physicians plan of care for certification period 1/16/15 to 3/16/15 with orders to include home health aide services 6 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/29/15 and 2/10/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record contained an undated document titled "Missed Visit Form" stating, "Patient: [patient #5] Date/Time of visit: 1/29/15 Type of Visit: HHA [home health aide] Staff Member: [Employee FF-home health aide] Reason: Other 'aide off on dr. [doctor] note, couldn't find replacement' How were the patient's needs met? [blank] Physician Notified: [blank]"</p>		<p>and the alteration of the time of visit, if any. Patients will be notified immediately by the assigned scheduler if any alteration in patient schedule time must be made due to unforeseen circumstances. Documentation will be made on a Communication Form, given to the assigned RN and placed in the chart of record once reviewed by the Administrator to ensure compliance of correction. RN will utilize Coordination of Care form created to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visits. RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>B. The record contained a document titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The record evidenced the next skilled nursing visit was conducted on 2/13/15 and failed to evidence the patient was notified of the change in the plan of care.</p> <p>1.) The record evidenced a physicians order from the wound center stating, "Date: 2/09/15 Time: 1500 ... Orders Note: Only those items checked will be carried out. ... DIAGNOSIS: Number/Location Wound #(s): '#3' Location: '[left] axilla' Dressing Orders Aquacel Ag/Gauze/Medipore ... Cleanse Wound(s) with: Normal Saline ... Physician or Physician Extender Signature: [physician at wound center] Date: 2/9/15 Time: 1525"</p> <p>2.) A document titled "Clinical</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>Note" states, "2-9-15 St. [Saint] Joseph Wound Center sent orders for pt [patient] to have daily dressing changes to wound to [left] axilla. Case manager notified. MD aware. Will begin dressing change 2/10/15 after pt receives wound care supplies. [employee K-registered nurse]." The document states, "2-10-15 Pt called et [and] stated [patient] hasn't received [patient's] supplies for wound care. Pt concerned about when wound care will start. Call [physician] at St. Joseph Wound Center to see if staff has ordered supplies. [employee K]." The document states, "2-12-15 1145 A [AM] - St. Joseph Wound Center called et stated pts supplies are now delivered. Called pts PCP [primary care physician] et notified him that office had order for wound care daily. MD stated to start wound care 2/13/15. [employee K]."</p> <p>3.) On 2/19/15 at 3:50 PM, employee K (registered nurse) indicated receiving a call from patient #5 on 2/10/15 with concerns of the skilled nurse not visiting for wound care. The employee indicated contacting the wound center on 2/10/15 in regards to wound care supplies. The employee indicated he/she failed to make contact with the patient in regards to plan for treatment.</p> <p>3. Clinical record #10 contained a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>physician's plan of care for certification period 12/17/14 to 2/14/15 with orders to include home health aide services 3 hours per day, 5 days per week for 60 days.</p> <p>The record failed to evidence home health aide services were conducted on 1/6/15, 1/9/15, and 1/12/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-6-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>B. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-9-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>C. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-12-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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 2/23/15 at 1:16 PM, employee D (administrator) indicated being unable to locate documentation of patient notification of the missed visits. The employee indicated the missed visit form needs to include documentation of how the patient's needs were met and documentation of any attempts of replacement.</p> <p>4. The agency policy with an effective date of 7/20/15, a revised date of 8/20/12, and a reviewed date as 7/25/14 titled "PATIENT RIGHTS AND RESPONSIBILITIES" states, "PATIENT'S RIGHTS ... 5. You have the right to expect the agency to have the proper resources to render safe care of the frequency of visits proposed. 6. You have the right to be told in advance what disciplines will furnish care and the frequency of visits proposed. ... 8 You have the right to know in advance of any change in your plan of care before the change is made."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
N 518 Bldg. 00	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on document and policy review, clinical record review, and observation, the agency failed to ensure patients were provided the current Advance Directives, including a description of applicable State law, for 3 of 3 home visit observations creating the potential to affect all 107 of the agency's current patients. (#2, #5, and #6)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 10/8/13, failed to evidence the patient had been presented an updated Advanced Directives document, revised July 2013.</p> <p>On 2/20/15 at 9 AM, a home visit was conducted to patient #2. The patient's admission packet failed to evidence the Indiana Advanced</p>	N 518	All appropriate staff will be in serviced on the following: The Home Health Aide will provide an updated and revised Indiana Advanced Directives document dated July 2013 to every existing patients home. The assigned RN will provide this document furnished by the Home Health Aide during every admission of a patient along with delivering document to existing patients during scheduled supervisory visits, skilled nurse visit and/or recertification visit determined by first available encounter. Every existing patient to have revised and updated Advanced Directives dated July 13 2013 in patient residence within 30 days of written correction. Administrator to ensure deficiency corrected by receiving a list in 30 days from each RN with documentation of completion. Policy created to ensure consistent patient	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>Directives document revised July, 2013.</p> <p>2. Clinical record #5, start of care 9/18/14, failed to evidence the patient had been presented an updated Advanced Directives document, revised July 2013.</p> <p>On 2/19/15 at 10:15 AM, a home visit was conducted to patient #5. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>3. Clinical record #6, start of care 6/20/14, failed to evidence the patient had been presented an updated Advanced Directives document, revised July 2013.</p> <p>On 2/20/15 at 10 AM, a home visit was conducted to patient #6. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>4. The policy with an effective date of 7/20/12 and reviewed date as 7/25/14 titled "CLIENT CLINICAL RECORD" states, "PROCEDURE: ... 9. The clinical record documents the following, using a standardized format, (clinical note): ... D. Information on any advance directives for care, as appropriate;"</p>		<p>scheduling visit times per MD order. RN to request and discuss time frame at admission for scheduling home health visits with patient of record. Once admission is complete, RN to call in admission information to ADON who will take completed information to appropriate scheduling employee to initiate scheduling of patient home health services. As per the information given at admission, the assigned scheduler will coordinate with the patient to ensure the home health visits are scheduled at the patient requested time and will be maintained at that time unless requested otherwise by the patient. In the instance an employee cannot fulfill the scheduled home health visit, the assigned scheduler will make every attempt to find an alternative home health aide to complete the patient's scheduled visit. The patient will maintain communication with the assigned scheduler regarding this process and the alteration of the time of visit, if any. Patients will be notified immediately by the assigned scheduler if any alteration in patient schedule time must be made due to unforeseen circumstances. Documentation will be made on a Communication Form, given to the assigned RN and placed in the chart of record once reviewed by the Administrator to ensure compliance of correction.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
N 522 Bldg. 00	<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, and interview, the agency failed to ensure visits were made as ordered on the plan of care in 4 of 7 active patients reviewed creating the potential to affect all 107 patients of the agency. (#2, #5, #6, and #10)</p> <p>Findings include:</p> <p>1. Clinical record #2 contained a physicians plan of care for certification period 12/2/14 to 1/30/15 with orders to include home health aide services 1 hour per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/10/15 and 1/11/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. On 2/20/15 at 9 AM, a home visit was conducted with patient #2. The patient indicated not having an aide for the dates of Saturday, 1/10/15 and</p>	N 522	All appropriate staff to be in serviced on the following: Daily huddles to be completed with each member of scheduling, case management, and HR every morning. At this time weekly schedules to be reviewed, indicating any unfilled visits, concerns, and missed visits that need addressed due to absences by home health aides. Daily Huddle Form to be utilized to ensure these topics are addressed. Assistant to Administrator to collect all forms and compile summary for Administrator. Administrator to ensure resolution occurs on all unfilled visits or concerns covered in daily huddle by end of business day. A policy has been established to address compliance with the agency responsibility to meet the needs of the patient once accepted into care. Patients will not be accepted for admission if the agency is not able to meet the needs of the patient upon initial assessment. The established policy is as follows: Policy: It is	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>Sunday, 1/11/15 and on 1/10/15, the patient contacted the office and spoke with employee CC (office staff) who reassured patient that an aide would arrive on 1/11/15. The patient indicated the aide failed to arrive again on 1/11/15 at which time the patient contacted the office and spoke to employee CC and was told the employee would "Look into it." The patient indicated not being contacted back from the agency.</p> <p>B. On 2/23/15 at 12:35 PM, employee E (alternate director of nursing) indicated it is the responsibility of the on-call staff to contact the patient and inform them of any changes or time differences for the scheduled visit.</p> <p>C. On 2/23/15 at 12:55 PM, employee E indicated being unable to locate documentation related to the missed home health aide visits on 1/10 and 1/11/15.</p> <p>2. Clinical record #5 contained a physicians plan of care for certification period 1/16/15 to 3/16/15 with orders to include home health aide services 6 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/29/15 and 2/10/15 and failed to evidence documentation of the patient's</p>		<p>the policy of the company to maintain patient care consistency per M.D. orders. As part of this policy it must be acknowledged that there are two types of missed visits. One, being a patient cancellation and tow, being agency staff cancellation. PROCEDURE: 1) Patient cancellation: will be addressed if the patient cancellation causes non compliance with the physician's order. A missed visit form will be completed and given to the Administrator and CM Nurse. Administrator to log in Missed Visit Log for tracking. If the patient has more than two cancellations within the current certification period, the patient will be discharged according to policy. 2) Agency staff cancellation will be addressed by utilizing all other home health aide staff, on call home health aide, all available agency staff from the scheduling staff, up the organizational chart, to the Administrator in order to maintain compliance. Non compliance with this policy is unacceptable and scheduling staff will be terminated if policy is not maintained. Communication forms to be utilized by scheduling and completed on every phone call taken regarding home health aide or patient. Once concern is documented, RN to be notified immediately to inform of situation. RN to instruct on resolution if scheduling can</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>notification prior to the missed visits.</p> <p>The record contained an undated document titled "Missed Visit Form" stating, "Patient: [patient #5] Date/Time of visit: 1/29/15 Type of Visit: HHA [home health aide] Staff Member: [Employee FF-home health aide] Reason: Other 'aide off on dr. [doctor] note, couldn't find replacement' How were the patient's needs met? [blank] Physician Notified: [blank]"</p> <p>3. Clinical record #6 contained a physicians plan of care for certification period 12/31/14 to 2/28/15 with orders to include home health aide services 3 hours per day, 7 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/6/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>The record evidenced a document dated 1/14/15 by employee N (registered nurse) titled "MISSED VISIT FORM" stating, "Patient: [patient #6] Date/Time of Visit: '1-6-15 10 A -1 P' Type of Visit: 'HHA [home health aide]' ... Reason: Other [checked] 'HHA called off and couldn't fill hours' How were patient's needs met? [blank]"</p>		<p>complete. Patient to be called back and documentation completed on every concern or request. Once resolution is completed and RN has signed and documented, all completed forms to go to Administrator for review and filing. Communication Form to be filed in patient chart, last tab, to ensure continuity of care, and show communication between scheduling, nursing and patient. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>4. Clinical record #10 contained a physicians plan of care for certification period 12/17/14 to 2/14/15 with orders to include home health aide services 3 hours per day, 5 days per week for 60 days. The record failed to evidence home health aide services were conducted on 1/6/15, 1/9/15, and 1/12/15 and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-6-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>B. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-9-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p> <p>C. The record evidenced a document dated 1/21/15 titled "MISSED VISIT FORM" stating, "Patient: [patient #10] Date/Time of Visit: '1-12-15 9 A -12 P' Type of Visit: 'HHA' ... Reason: Other [checked] How were patient's needs met? [blank]"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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			
N 524 Bldg. 00	<p>D. On 2/23/15 at 1:16 PM, employee D (administrator) indicated being unable to locate documentation of patient notification of the missed visits. The employee indicated the missed visit form needs to include documentation of how the patient's needs were met and documentation of any attempts of replacement.</p> <p>5. The agency policy with an effective date as 7/20/12 and a reviewed date of 7/25/14 titled "MISSED VISIT" states, "POLICY: It is the policy of the company to maintain patient care consistency per M.D. [medical doctor] orders. ... PROCEDURE: 1. A missed visit occurs when the physician-ordered frequency of services is not maintained. ... 3. A missed visit constitutes a modification in the plan of care and the physician must be notified."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>(B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record review, policy review, observation, and interview, the agency failed to ensure the plan of care included medications in 1 of 10 clinical records reviewed creating the potential to affect all patient's of the agency. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained plan of care for certification period 1/16/15 to 3/16/15 with orders to include skilled nursing services and home health aide services. The plan of care failed to include an updated medication list.</p> <p>A. On 2/19/15 at 10:15 AM, a home visit was conducted with patient #5 to observe care being provided by the home</p>	N 524	All appropriate staff will be in serviced on the following: Medication Profile will be reviewed at every patient visit including supervisory visits, skilled nursing visits, recertification and any assessment per MD order. ADON to review all completed visit/assessment documentation. Monthly audits to be completed to ensure medication review was completed on each patient during visits. Patient letter given to every patient upon admission stating patient to inform RN by calling office if any changes in medications occur between scheduled visits. If medication changes occur, RN will add medication to Medication Profile in patient home and clinical chart. RN will notify MD to verify	03/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>health aide (employee Z). At 10:45 AM, employee Z was asked about the task of providing foot care. The employee indicated after assistance with showering, the employee rubs a cream on the patient's feet. The employee presented the cream to the surveyor at which time it was observed to be a prescription medication of Econazole Nitrate 1% cream (a topical antifungal cream). The employee indicated the cream is put on the feet, but not in between the toes, and then the employee will place the patient's socks on "to keep it all in." The employee indicated someone in the office had told her to perform this task about a month ago but could not remember the staff member who told this to her.</p> <p>The record contained a document titled "MEDICATION PROFILE" with a review date of 2/11/15 by employee N (registered nurse/case manager). The document and the plan of care failed to list Econazole Nitrate 1% cream as a current medication used by the patient.</p> <p>B. The document titled "MEDICATION PROFILE" (with a review date of 2/11/15 by employee N) and the plan of care failed to list Cleocin T 1% as a medication presently being used by the patient.</p>		change and document in clinical note. ADON will review all clinical documentation and monitor any follow up needed. Administrator will meet daily with ADON to ensure RN has followed up and resolution/documentation is complete.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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. On 2/19/15 at 11:05 AM, during the home visit with patient #5, the patient indicated using the Econazole Nitrate 1% cream on his/her feet for a while and it was being used before the wound appeared under the left axillary. The patient indicated the doctor prescribed this to be used on his/her feet and legs.</p> <p>D. On 2/19/15 at 11:10 AM, during the home visit with patient #5, employee J (licensed practical nurse) notified employee N (registered nurse/case manager) via telephone. Employee J discussed with employee N the use by the patient of the Econazole Nitrate 1% cream and employee J stated to employee N, "On new med sheet, I couldn't find it, the one [medication profile sheet] that you sent, because we got the Eucerin Cream to [patient's] feet and legs. It is on the old one [medication profile sheet] that was here. You have it written as Cleosin, left axillary BID [two times per day] but its not [listed] on the new one [medication profile sheet]." The patient then stated, "I have been using that on my feet and legs before I ever had a hole [wound in left axillary]." The patient indicated is was prescribed by the doctor because of bumps on his/her legs that kept "busting open." Employee J ended the call with employee N and indicated the RN (employee N) would have to</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>clarify the Econazole Nitrate 1% cream with the physician because the RN (employee N) was not aware of the patient having that medication.</p> <p>E. On 2/20/15 at 12:45 PM, an interview was conducted with employee N (registered nurse / case manager). The employee indicated never seeing the Econazole Nitrate 1% cream in the patient's home before and indicated the patient never told of use this medication.</p> <p>2. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "Plan of Care" states, "POLICY: A written plan of care shall be developed for each client admitted to home care for skilled treatment in consultation with the home health professional staff, the patient's physician, the patient and members of the patient's family. PURPOSE: 1. To ensure delivery of health care services that are medically required for the client. ... PROCEDURE: Plan of Treatment ... 3. The plan of care will include physician orders for Medications and Treatments"</p> <p>3. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PATIENT MEDICATION" states, "PROCEDURE Administration of Medications ... 11. The current</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
N 527 Bldg. 00	<p>medication profile, listing medications, home remedies, over the counter drugs and side effects, will be recorded on the client medication form and maintained in the client's record."</p> <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. Based on clinical record review, policy review, and interview, the agency failed to ensure agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care in 1 of 7 active patient's records reviewed. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained a plan of care for certification period 9/18 to 11/16/14 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p>	N 527	All appropriate staff will be in serviced on the following: RN will utilize Coordination of Care form created to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visits. RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. If LPN completes skilled visit on patient, LPN will utilize Communication Form to communicate with CM to any changes to patient condition. Administrator to ensure	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>A. The record contained a document signed by employee N (registered nurse) on 9/18/14 titled "Comprehensive Adult Nursing Assessment" stating, "Date '09/18/14' Reason for Visit: Start of Care [checked] ... [page 6 of 20] INTEGUMENTARY STATUS ... Turgor Good Rash Dry Bruises Other (specify) 'redness under abd. [abdominal] folds, under left axilla' ... [page 9 of 20] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Left Axilla [axillary-arm pit]' Type: ... 'Open boil' Size (cm) [centimeter] (LxWxD) [length times width times depth] '1.2 cm x 1.6 cm' ... [page 16 of 20] CARE MANAGEMENT ... d. Medical Procedures/Treatments (e.g. changing wound dressing) 0 [checked] - No Assistance Needed in this Area ... [page 17 of 20] THERAPY AND PLAN OF CARE ... (M2250) Plan of Care Synopsis: ... Plan/Intervention a. Patient-Specific parameters for notifying physician of changes in vital signs or other clinical findings n/a [checked] Not applicable Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference ... Plan/Intervention e. Intervention(s) to monitor and mitigate</p>		<p>deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made. Policy on pain protocols created to provide proper procedure on identifying pain and addressing with MD for resolution. RN to establish baseline pain upon admission with patient. RN to document in patient assessment document and on 485 assessment. RN to address pain at each nurse visit and supervisory visit. RN to notify MD of any pain identified outside of baseline. RN to document any instructions from MD on resolution of symptoms. RN to notify patient and implement instructions given with patient. RN to document in clinical chart notification and instructions to patient and any/all follow up to ensure resolution. ADON to review all clinical notes written by RN to ensure proper procedures are followed and documentation completed appropriately. Administrator to ensure procedure is being followed and compliance is maintained.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>pain 1 [checked] - Yes" The record failed to evidence the registered nurse addressed the wound with the physician.</p> <p>B. The record contained a document dated 10-20-14 by employee J [LPN-Licensed Practical Nurse] titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 10-20-14 ... Pain Rating '8/10' Pain Area 'arm pit' ... Note: 'med set up completed. Assessment and vs [vital signs] WNL [within normal limits]. Pt to go to ER [emergency room] for outpatient surgery for cyst under [left] arm. Rates pain 8/10 to that area. Discussed safety with transfers. The document failed to evidence the patients pain level (8 out of 10) or the patient's verbal report of outpatient surgery was addressed with the physician or case manager.</p> <p>C. The record contained a document dated 11-3-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-3-14 ... Pain Rating '7/10' Pain Area 'stomach' ... Note: 'med set up completed. Assessment and vs completed WNL. No edema noted. Rates stomach pain 7/10. underarm [left] has 4 holes Pt has medication BID to area. discussed using med as directed'" The record failed to evidence the LPN notified the physician</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>or case manager of the patient's change in wound status and pain rating of 7/10.</p> <p>D. The record contained a document dated 11-10-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-10-14 ... Note: 'Patient continues topical medication to wound in left axilla per MD order. Moderate serosanguineous drainage [with] odor. After pt. lifted [left] arm to put medicine on, moderate amount of dark blood, thick, from 4 areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>E. The record contained a document signed by employee N (registered nurse) on 11/14/14 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? Yes [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 3 [checked] - daily, but not constantly ... [page 5 of 14]</p> <p>INTEGUMENTARY STATUS (Cont'd)</p> <p>... WOUND CARE: (check all that apply) Wound care done during this visit: Yes [checked] Location(s) wound site: 'left axilla' ... Technique: Clean [checked] ... Patient tolerated procedure well: Yes [checked] ... [page 6 of 14]</p> <p>INTEGUMENTARY STATUS (Cont'd)</p> <p>Wound/Lesion #1 Location 'Proximal Left axilla' Type: 'abscess' Size: '0.6 x 0.5' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #2 Location '[left] axilla' Type: 'abscess' Size: '0.3 x 0.4' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #3 Location '[left] axilla' Type: 'abscess' Size: '0.4 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #4 Location 'lateral [left] axilla' Type: 'abscess' Size: '0.7 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Color Other [checked] Consistency Thick [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>F. The record contained a document dated 11-24-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '11-24-14' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'Open areas to [left] axilla are now 2, was previously 4 smaller areas. Drainage noted, skin around pink. Pt complains of burning to areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>G. The record contained a document dated 12-8-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '12-8-14' ... Pain Rating '8/10' Pain Area 'Headache [Left] axilla ... Note: 'Pt. compliant [with] medications thru [through] previous week med set up. ... 1.5 cm x 3.1 cm x 0.2 cm deep [with] no tunneling. Serosanguineous drng [drainage] noted.'" The record failed to evidence the RN contacted the physician with the change in wound status and pain of 8 out of 10.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>H. The record contained a document dated 12-22-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 12-22-14 ... Pain Rating '9/10' Pain Area 'HA [headache]' ... SKIN WNL [checked] ... *Describe rash or wounds in note below including measurements. ... Note: 'med set up completed. Assessment and vs completed WNL. Rates HA 9/10. No edema noted BLE [bilateral lower extremities]. Discussed pt HA's and medication safety'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 9 out of 10.</p> <p>I. The record contained a document dated 1-5-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-5-15' ... Pain Rating 6/10 Pain Area 'back /[left] axilla' SKIN ... * Describe rash or wounds in note below including measurements ... Note: 'Pt compliant [with] meds through previous set up. Pt. tolerates visit well. Complains of headache and pain too back and left axilla wound. Wound has foul odor and drainage noted, MD aware.'" The record failed to evidence documentation of physician notification of wound status and pain rating.</p> <p>J. The record contained a document</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>signed by employee N (registered nurse) on 1/12/15 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? No Problem [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 2 [checked] - Less often than daily ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: No [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location '[Left] axilla' Type: 'abscess' Size (cm) (LxWxH [length times width times height]): '2.1 cm x 4.6 cm x 0.2 cm' Tunneling [zero] Stage [zero] Odor 'Y' Surrounding Skin 'Intact' Edema 'Y' ... Appearance of the wound bed 'Granulated red' Drainage/Amount Small [checked]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Color Serosanguineous [checked] Consistency Thin [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>K. The record contained a document dated 1-26-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-26-15' ... Pain Rating 7/10 Pain Area '[left] Ab [abdominal] fold ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... '[patient] reports MD called [patient] on 1-23-15 and told [patient] to go to the ER to have area on [left] [abdominal] fold drained but said [patient] didn't have a ride and today its too cold'" The record failed to evidence documentation of physician notification of the patient not reporting to the ER for the draining of the abscess.</p> <p>L. The record contained a document dated 2-2-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '2-2-15' ... Pain Rating '8/10' Pain Area 'Headache' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... 'Pt. tolerates visit well. ... Area has minimal drainage at this time [with] foul odor. Pt. c/o [complains of] tenderness to area. No s/s [signs and symptoms] of infection</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>noted.'" The failed to evidence documentation of physician notification of patient's pain level of 8 out of 10.</p> <p>M. The record contained a document dated 2/9/15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' Time in 4:40 p Time Out 5:00 PM ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Skin *describe rash or wounds in note below including measurements. ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The record failed to evidence the physician had been notified of the patient's pain rating of an 8 out of a 0-10 scale.</p> <p>N. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 7 out of 10.</p> <p>2. On 2/19/15 3:15 PM, employee D (administrator) indicated staff are educated to report increased pain to the physician. The employee indicated being unable to locate documentation of the patient's baseline (tolerable) pain level.</p> <p>3. On 2/20/15 at 12:45 PM, an interview with employee N (case manager/registered nurse) was conducted. The employee indicated the patient started services 9/18/14 and upon initial assessment, a wound in the left axillary had been identified. The employee indicated, according to the patient, the wound was evaluated by the physician but no orders for treatment were given. Employee N indicated there was no communication with the physician regarding the evaluation of the wound. The employee indicated at the 11/14/14 recertification assessment, the wound was changed and had become 4 small wounds. The employee indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>being unable to locate documentation in the chart of physician notification of this and indicated being unable to locate documentation the chart evidencing a follow-up had been made. Employee N indicated the wounds had another change and the 4 wounds then become 2. The employee indicated being unable to locate documentation in the record to evidence physician notification. Employee N indicated at the 1/12/14 recertification assessment, the 2 wounds had become 1. The employee indicated on 1/19/15, a second wound on the patient's abdominal fold was discovered at which time the physician was notified and an appointment was scheduled for 1/21/15. Employee N indicated on 1/21/15, the patient informed the employee of physician contact and of an appointment scheduled to a surgeon to address the wounds on 2/4/15. The employee indicated the patient was directed to go to the ER on 1/23/15 by the physician and have the abscess on the abdominal fold drained but failed to go and the employee indicated being unable to locate documentation in the clinical record of the physician's notification of this.</p> <p>4. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "Plan of Care" states, "POLICY: A</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>written plan of care shall be developed for each client admitted to home care for skilled treatment in consultation with the home health professional staff, the patient's physician, the patient and members of the patient's family.</p> <p>PURPOSE: 1. To ensure delivery of health care services that are medically required for the client. ... PROCEDURE: Plan of Treatment 1. Home health services are furnished to clients under the physician's certification that the services are medically required for the client. ...</p> <p>2. The plan of care for each patient will include: ... All pertinent diagnoses ... 4. The forms: Oasis Start of Care (initial assessment), Patient medications, assessment summary, physician's orders and patient problem list constitute the Plan of Care and are submitted by the case manager and professional team members to the agency within 4 working days of the start of care date. ... 6. RN [registered nurse] case manager, therapists promptly inform the physician of any changes that suggest a need to alter the plan of care. 7. All changes in the plan of care are documented through written and signed physician orders."</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0484" states, "Communications policy and procedure: PURPOSE: To</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>maintain effective communications to assure that all personnel providing services shall appropriately complement on another and support the objectives of the patient's care. POLICY: Communication regarding patient's care shall be documented in the clinical record. ... Field staff will communicate all pertinent information to nursing supervisor and/or nurse case manager of that patient's case. Nursing supervisors will review any new orders with or information with field staff for cases they are working on. The nursing supervisors will promptly alert the physician of any changes that suggest a need to alter the medical plan of care. ... The nursing supervisor will notify the patient's physician or other appropriate licensed professional staff and legal representatives, if any, of any significant physical or mental changes observed are reported by the patient. ... "</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PHYSICIAN ORDERS" states, "POLICY: Every patient will have an individualized plan of care based on the medical, functional and psychosocial needs of each patient. Home care staff shall administer care and treatment according to the specific individualized instructions of the patient;s designated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
N 545 Bldg. 00	<p>primary physician. ... PURPOSE: ... 2. To facilitate quality improvement in the receipt of physician orders. ...</p> <p>PROCEDURE: 1. Physician orders are initiated when physician or referral source requests skilled services, and required prior any care is initiated, either verbally or in writing. ... 3. Physician verbal or telephone orders for care are recorded and verified by appropriate qualified and licensed professional staff members. ... A. The physician will be notified immediately of any changes in the patient's condition which indicate changes to the plan of treatment. ... Medical Supervision ... 10. The agency will ensure that communication with the physician is timely, appropriate and consistent with the needs of the patient. ... "</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record review, observation, policy review, and interview, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively in 1 of 7 active patients reviewed creating the potential to</p>	N 545	All appropriate staff will be in serviced on the following: RN will utilize Coordination of Care form created to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visits	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>affect all patients of the agency. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained a plan of care for certification period 9/18 to 11/16/14 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>A. The record contained a document signed by employee N (registered nurse) on 9/18/14 titled "Comprehensive Adult Nursing Assessment" stating, "Date '09/18/14' Reason for Visit: Start of Care [checked] ... [page 6 of 20] INTEGUMENTARY STATUS ... Turgor Good Rash Dry Bruises Other (specify) 'redness under abd. [abdominal] folds, under left axilla' ... [page 9 of 20] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Left Axilla [axillary-arm pit]' Type: ... 'Open boil' Size (cm) [centimeter] (LxWxD) [length times width times depth] '1.2 cm x 1.6 cm' ... [page 16 of 20] CARE MANAGEMENT ... d. Medical</p>		<p>(included but not limited to wound dressing changes). RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made. Policy on pain protocols created to provide proper procedure on identifying pain and addressing with MD for resolution. RN to establish baseline pain upon admission with patient. RN to document in patient assessment document and on 485 assessment. RN to address pain at each nurse visit and supervisory visit. RN to notify MD of any pain identified outside of baseline. RN to document any instructions from MD on resolution of symptoms. RN to notify patient and implement instructions given with patient. RN to document in clinical chart notification and instructions to patient and any/all follow up to ensure resolution. ADON to review all clinical notes written by RN to ensure proper procedures</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>Procedures/Treatments (e.g. changing wound dressing) 0 [checked] - No Assistance Needed in this Area ... [page 17 of 20] THERAPY AND PLAN OF CARE ... (M2250) Plan of Care Synopsis: ... Plan/Intervention a. Patient-Specific parameters for notifying physician of changes in vital signs or other clinical findings n/a [checked] Not applicable Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference ... Plan/Intervention e. Intervention(s) to monitor and mitigate pain 1 [checked] - Yes" The record failed to evidence the registered nurse addressed the wound with the physician.</p> <p>B. The record contained a document dated 10-14-14 by employee N titled "HHA Supervisory Visit" stating, "Patient Name [patient #5] Date of visit '10-14-14' ... Please list any patient concerns and/or HHA training you feel is needed '[left] armpit - now 3 open areas where draining large amount serosanguineous, slight odor, skin around red'"</p> <p>A document titled "CLINICAL NOTE" states, "10-14-14 During a sup visit nurse asked pt how area under</p>		<p>are followed and documentation completed appropriately. Administrator to ensure procedure is being followed and compliance is maintained. Home Health Agency to provide supplies for any wound care ordered by MD until supplies are delivered in order to provide continuity of care to patient. RN to notify Administrator of needs. Account set up at Moore's Home Health store in order to allow RN to purchase supplies needed in a timely manner. Medication Profile will be reviewed at every patient visit including supervisory visits, skilled nursing visits, recertification and any assessment per MD order. ADON to review all completed visit/assessment documentation. Monthly audits to be completed to ensure medication review was completed on each patient during visits. Patient letter given to every patient upon admission stating patient to inform RN by calling office if any changes in medications occur between scheduled visits. If medication changes occur, RN will add medication to Medication Profile in patient home and clinical chart. RN will notify MD to verify change and document in clinical note. ADON will review all clinical documentation and monitor any follow up needed. Administrator will meet daily with ADON to ensure RN has followed up and resolution/documentation is</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>[patients] left axilla was doing and [patient] stated it had been draining even more. Nurse assessed area and pt now has 3 open areas to left axilla that are still draining large amounts of serosanguineous drainage [with] slight odor. skin surround is read and patient reports that [patient's] left arm hurts at times. Nurse call MD office while in home and scheduled appt [appointment] for Friday Oct [October] 17th at 11:30 AM to have the area evaluated. [employee N-registered nurse]." The record failed to evidence the registered nurse followed-up on the patient's 10/17/14 visit with the physician.</p> <p>C. The record contained a document dated 10-20-14 by employee J [LPN-Licensed Practical Nurse] titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 10-20-14 ... Pain Rating '8/10' Pain Area 'arm pit' ... Note: 'med set up completed. Assessment and vs [vital signs] WNL [within normal limits]. Pt to go to ER [emergency room] for outpatient surgery for cyst under [left] arm. Rates pain 8/10 to that area. Discussed safety with transfers. The document failed to evidence the patients pain level (8 out of 10) or the patient's verbal report of outpatient surgery was addressed with the physician or case manager.</p>		<p>complete. Case Conference/Care Pathway form updated to provide specific planning suggestions by clinical staff. RN to complete Case Conference on every existing patient. Once Case Conference planning suggestions have been documented, RN will resolve and document resolution on Case Conference document. All participatory staff will sign document which is to be filed in appropriate binder and kept by ADON. Administrator to review Case Conference resolutions weekly at set nursing staff meeting to ensure compliance. Policy created to provide specific scope of practices for home health aides. This policy states that home health aides are not to give any prescription medications to patients. Home Health Aides are allowed, if care plan states, to provide medication reminders to patient. No home health aide will provide any topical application of prescription cream to patient without specific written instructions to home health aide by RN per MD orders, along with training on application provided by RN on every home health aide providing services to patient. RN to observe home health aide properly applying prescription cream to patient and document such in clinical chart. Home Health Aide to be checked off on skill quarterly by outside licensed medical professional in order to maintain compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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. The record contained a document dated 11-3-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-3-14 ... Pain Rating '7/10' Pain Area 'stomach' ... Note: 'med set up completed. Assessment and vs completed WNL. No edema noted. Rates stomach pain 7/10. underarm [left] has 4 holes Pt has medication BID to area. discussed using med as directed'" The record failed to evidence the LPN notified the physician or case manager of the patient's change in wound status and pain rating of 7/10.</p> <p>E. The record contained a document dated 11-10-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-10-14 ... Note: 'Patient continues topical medication to wound in left axilla per MD order. Moderate serosanguineous drainage [with] odor. After pt. lifted [left] arm to put medicine on, moderate amount of dark blood, thick, from 4 areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>F. The record contained a plan of care for certification period 11/17/15 to 1/15/15 with orders to include skilled nursing services 1 time per week for 60</p>		Administrator to ensure compliance is maintained by reviewing HR file audits monthly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>G. The record contained a document signed by employee N (registered nurse) on 11/14/14 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? Yes [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 3 [checked] - daily, but not constantly ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: Yes [checked] Location(s) wound</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>site: 'left axilla' ... Technique: Clean [checked] ... Patient tolerated procedure well: Yes [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd)</p> <p>Wound/Lesion #1 Location 'Proximal Left axilla' Type: 'abscess' Size: '0.6 x 0.5' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #2 Location '[left] axilla' Type: 'abscess' Size: '0.3 x 0.4' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]</p> <p>Wound/Lesion #3 Location '[left] axilla' Type: 'abscess' Size: '0.4 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #4 Location 'lateral [left] axilla' Type: 'abscess' Size: '0.7 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>H. The record contained a document dated 11-24-14 by employee N titled "Nurse Care Visit Note" stating, "Patient</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Name [patient #5] Date '11-24-14' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'Open areas to [left] axilla are now 2, was previously 4 smaller areas. Drainage noted, skin around pink. Pt complains of burning to areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p> <p>I. The record contained a document dated 12-8-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '12-8-14' ... Pain Rating '8/10' Pain Area 'Headache [Left] axilla ... Note: 'Pt. compliant [with] medications thru [through] previous week med set up. ... 1.5 cm x 3.1 cm x 0.2 cm deep [with] no tunneling. Serosanguineous drng [drainage] noted.'" The record failed to evidence the RN contacted the physician with the change in wound status and pain of 8 out of 10.</p> <p>J. The record contained a document dated 12-22-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 12-22-14 ... Pain Rating '9/10' Pain Area 'HA [headache]' ... SKIN WNL [checked] ... *Describe rash or wounds in note below including measurements. ... Note: 'med set up completed. Assessment and vs</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>completed WNL. Rates HA 9/10. No edema noted BLE [bilateral lower extremities]. Discussed pt HA's and medication safety'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 9 out of 10.</p> <p>K. The record contained a document dated 1-5-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-5-15' ... Pain Rating 6/10 Pain Area 'back /[left] axilla' SKIN ... * Describe rash or wounds in note below including measurements ... Note: 'Pt compliant [with] meds through previous set up. Pt. tolerates visit well. Complains of headache and pain too back and left axilla wound. Wound has foul odor and drainage noted, MD aware.'" The record failed to evidence documentation of physician notification of wound status and pain rating.</p> <p>L. The record contained a plan of care signed by the attending physician on 1/15/15 for certification period 1/16/15 to 3/16/15 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>activities of daily living] as per home health aide care plan.</p> <p>M. The record contained a document signed by employee N (registered nurse) on 1/12/15 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? No Problem [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 2 [checked] - Less often than daily ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: No [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location '[Left] axilla' Type: 'abscess' Size (cm) (LxWxH [length times width times height]): '2.1 cm x 4.6 cm x 0.2 cm' Tunneling [zero]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Stage [zero] Odor 'Y' Surrounding Skin 'Intact' Edema 'Y' ... Appearance of the wound bed 'Granulated red' Drainage/Amount Small [checked] Color Serosanguineous [checked] Consistency Thin [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>N. The record contained a document dated 1-26-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-26-15' ... Pain Rating 7/10 Pain Area '[left] Ab [abdominal] fold ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... '[patient] reports MD called [patient] on 1-23-15 and told [patient] to go to the ER to have area on [left] [abdominal] fold drained but said [patient] didn't have a ride and today its too cold'" The record failed to evidence documentation of physician notification of the patient not reporting to the ER for the draining of the abscess.</p> <p>O. The record contained a document dated 2-2-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '2-2-15' ... Pain Rating '8/10' Pain Area 'Headache' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... 'Pt.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>tolerates visit well. ... Area has minimal drainage at this time [with] foul odor. Pt. c/o [complains of] tenderness to area. No s/s [signs and symptoms] of infection noted.'" The record failed to evidenced the RN assessed the wounds (to include measurements), failed to evidence the patient's pain level was addressed, and failed to evidence documentation of physician notification of patient's pain level of 8 out of 10.</p> <p>P. The record contained a document dated 2/9/15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' Time in 4:40 p Time Out 5:00 PM ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Skin *describe rash or wounds in note below including measurements. ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen] fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The document failed to evidence the RN had provided wound assessment to include measurements. The record failed to evidence the</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>physician had been notified of the patient's pain rating of an 8 out of a 0-10 scale.</p> <p>A document titled "CLINICAL NOTE" states, "2-10-15 Pt called et [and] stated [patient] hasn't received [patient's] supplies for wound care. Pt concerned about when wound care will start. Call [physician] at St. Joseph Wound Center to see if staff has ordered supplies. [employee K]."</p> <p>Q. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the case manager of the pain level of 7 out of 10 and failed to evidence the LPN assessed the abdominal fold abscess.</p> <p>R. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 7 out of 10.</p> <p>S. The record contained a document titled "HOME HEALTH AIDE CARE PLAN" with a date of review by employee N (registered nurse/case manager) on 1-12-15 to include foot care daily as an assigned task.</p> <p>1.) On 2/19/15 at 10:15 AM, a home visit was conducted with patient #5 to observe care being provided by the home health aide (employee Z). At 10:45 AM, employee Z was asked about the task of providing foot care. The employee indicated after assistance with showering, the employee rubs a cream on the patient's feet. The employee presented the cream to the surveyor at which time it was observed to be a prescription medication of Econazole Nitrate 1% cream, a topical antifungal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>medication. The employee indicated the cream is put on the feet, but not in between the toes, and then the employee will place the patient's socks on "to keep it all in." The employee indicated someone in the office had told her to perform this task about a month ago but could not remember the staff member who told this to her.</p> <p>The record contained a document titled "MEDICATION PROFILE" with a review date of 2/11/15 by employee N (registered nurse/case manager). The document failed to list Econazole Nitrate 1% cream as a current medication used by the patient.</p> <p>2.) On 2/19/15 at 10:55 AM, during the home visit with patient #5, an interview was conducted with employee J (licensed practical nurse) who was present for a scheduled skilled nursing visit. The employee indicated the Econazole Nitrate 1% cream was listed on the medication profile as Cleocin T 1% (a topical antibiotic) and is to be applied to the left axillary wound two times per day. The employee indicated the Cleocin T 1% cream was prescribed on 10/29/14. The employee stated, "This is to be under [patient's] arm, not on her feet."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>3.) On 2/19/15 at 11:05 AM, during the home visit with patient #5, the patient indicated using the Econazole Nitrate 1% cream on his/her feet for a while and it was being used before the wound appeared under the left axillary. The patient indicated the doctor prescribed this to be used on his/her feet and legs.</p> <p>4.) On 2/19/15 at 11:10 AM, during the home visit with patient #5, employee J (licensed practical nurse) notified employee N (registered nurse/case manager) via telephone. Employee J discussed with employee N the use by the patient of the Econazole Nitrate 1% cream and employee J stated to employee N, "On new med sheet, I couldn't find it, the one [medication profile sheet] that you sent, because we got the Eucerin Cream to [patient's] feet and legs. It is on the old one [medication profile sheet] that was here. You have it written as Cleosin, left axillary BID [two times per day] but its not [listed] on the new one [medication profile sheet]." The patient then stated, "I have been using that on my feet and legs before I ever had a hole [wound in left axilla]." The patient indicated is was prescribed by the doctor because of bumps on his/her legs that kept "busting open." Employee J ended the call with employee N and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>indicated the RN (employee N) would have to clarify the Econazole Nitrate 1% cream with the physician because the RN (employee N) was not aware of the patient having that medication.</p> <p>5.) On 2/20/15 at 12:45 PM, an interview was conducted with employee N (registered nurse/ case manager). The employee indicated never seeing the Econazole Nitrate 1% cream in the patient's home before and indicated the patient never told of use this medication. The employee indicated sending a fax to the patient's primary physician on 2/19/15 requesting information on the cream. The employee indicated the cream is to be used BID for rashes. The employee indicated not providing instructions to the home health aide to perform this task.</p> <p>2. A document dated 11/14/14 titled "CASE CONFERENCE" states, "Patient Name [patient #5] Date '11-14-14' Summary of meeting: 'Patient has had abscess under left axilla for few months now. Area had opened and MD was notified. Pt seen MD and referred to surgeon. The surgeon opted for no surgery and gave [patient] medicine to apply daily to area. The wound site is now 4 open holes and [patient] has large dark drainage from areas daily. Pt is able too roll on the medicine to areas but I feel</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>that these haven't been treated properly and aren't healing. Areas need to be washed and irrigated, medicine applied and dry dressing applied to area daily' Meeting Attendees [employee N-case manager/registered nurse] ... [employee W-registered nurse] [employee J-LPN] [employee D-administrator]."</p> <p>A. On 2/19/15 at 4:15 PM, employee E (alternate administrator) indicated the case conference document suggests that the open areas were identified and the need to alter the plan of care should have been addressed but was not.</p> <p>B. On 2/19/15 at 3:15 PM, employee E indicated the skilled nurse should have addressed the wound with the physician on admission.</p> <p>3. On 2/19/15 3:15 PM, employee D (administrator) indicated staff are educated to report increased pain to the physician. The employee indicated being unable to locate documentation of the patient's baseline (tolerable) pain level.</p> <p>4. On 2/20/15 at 12:50 PM, during the interview with employee N (case manager / registered nurse), the employee indicated the patient started services 9/18/14 and upon initial assessment, a wound in the left axillary had been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>identified. The employee indicated, according to the patient, the wound was evaluated by the physician but no orders for treatment were given. Employee N indicated there was no communication with the physician regarding the evaluation of the wound. The employee indicated at the 11/14/14 recertification assessment, the wound was changed and had become 4 small wounds. The employee indicated being unable to locate documentation in the chart of physician notification of this and indicated being unable to locate documentation the chart evidencing a follow-up had been made. Employee N indicated the wounds had another change and the 4 wounds then become 2. The employee indicated being unable to locate documentation in the record to evidence physician notification. Employee N indicated at the 1/12/14 recertification assessment, the 2 wounds had become 1. The employee indicated on 1/19/15, a second wound on the patient's abdominal fold was discovered at which time the physician was notified and an appointment was scheduled for 1/21/15. Employee N indicated on 1/21/15, the patient informed the employee of physician contact and of an appointment scheduled to a surgeon to address the wounds on 2/4/15. The employee indicated the patient was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>directed to go to the ER on 1/23/15 by the physician and have the abscess on the abdominal fold drained but failed to go and the employee indicated being unable to locate documentation in the clinical record of the physician's notification of this.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0484" states, "Communications policy and procedure: PURPOSE: To maintain effective communications to assure that all personnel providing services shall appropriately complement on another and support the objectives of the patient's care. POLICY: Communication regarding patient's care shall be documented in the clinical record. ... Field staff will communicate all pertinent information to nursing supervisor and/or nurse case manager of that patient's case. Nursing supervisors will review any new orders with or information with field staff for cases they are working on. The nursing supervisors will promptly alert the physician of any changes that suggest a need to alter the medical plan of care. ... The nursing supervisor will notify the patient's physician or other appropriate licensed professional staff and legal representatives, if any, of any significant physical or mental changes observed are</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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
N 546 Bldg. 00	<p>reported by the patient. ... "</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PHYSICIAN ORDERS" states, "PROCEDURE: ... 10. The agency will ensure that communication with the physician is timely, appropriate and consistent with the needs of the patient. ... "</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. Based on clinical record review, policy review, observation and interview, the agency failed to ensure the registered nurse informed the physician of changes in the patient's condition and needs in 1 of 7 active patient records reviewed</p>	N 546	RN will utilize Coordination of Care form created to be filled out at admission and updated at each nurse visit. The RN will notify the MD of record of any medical changes identified at home visits.	03/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015	
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902			
(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>creating the potential to affect all patients of the agency. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5 contained a plan of care for certification period 9/18 to 11/16/14 with orders to include skilled nursing services 1 time per week for 60 days for assessment and medication set-up and home health aide services 6 hours per day, 7 days per week for 60 days to assist with ADL's [activities of daily living] and IADLs [instrumental activities of daily living] as per home health aide care plan.</p> <p>A. The record contained a document signed by employee N (registered nurse) on 9/18/14 titled "Comprehensive Adult Nursing Assessment" stating, "Date '09/18/14' Reason for Visit: Start of Care [checked] ... [page 6 of 20] INTEGUMENTARY STATUS ... Turgor Good Rash Dry Bruises Other (specify) 'redness under abd. [abdominal] folds, under left axilla' ... [page 9 of 20] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Left Axilla [axillary-arm pit]' Type: ... 'Open boil' Size (cm) [centimeter] (LxWxD) [length times width times depth] '1.2 cm x 1.6 cm' ... [page 16 of 20] CARE</p>		<p>RN will document any findings in clinical note along with instructions from MD notification. RN will notify patient of any changes to plan of care per MD orders and instructions and document notification. RN will follow up on changes of care plan and document progression of care in clinical chart. Auditing staff will review charts monthly to ensure documentation is complete. Administrator to ensure deficiency corrected and compliance maintained by requiring auditing staff to communicate all auditing completed monthly along with revisions made.</p> <p>Policy on pain protocols created to provide proper procedure on identifying pain and addressing with MD for resolution. RN to establish baseline pain upon admission with patient. RN to document in patient assessment document and on 485 assessment. RN to address pain at each nurse visit and supervisory visit. RN to notify MD of any pain identified outside of baseline. RN to document any instructions from MD on resolution of symptoms. RN to notify patient and implement instructions given with patient. RN to document in clinical chart notification and instructions to patient and any/all follow up to ensure resolution. ADON to review all clinical notes written by RN to ensure proper procedures are followed and documentation completed appropriately.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>MANAGEMENT ... d. Medical Procedures/Treatments (e.g. changing wound dressing) 0 [checked] - No Assistance Needed in this Area ... [page 17 of 20] THERAPY AND PLAN OF CARE ... (M2250) Plan of Care Synopsis: ... Plan/Intervention a. Patient-Specific parameters for notifying physician of changes in vital signs or other clinical findings n/a [checked] Not applicable Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference ... Plan/Intervention e. Intervention(s) to monitor and mitigate pain 1 [checked] - Yes" The record failed to evidence the registered nurse addressed the wound with the physician.</p> <p>B. The record contained a document dated 10-20-14 by employee J [LPN-Licensed Practical Nurse] titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 10-20-14 ... Pain Rating '8/10' Pain Area 'arm pit' ... Note: 'med set up completed. Assessment and vs [vital signs] WNL [within normal limits]. Pt to go to ER [emergency room] for outpatient surgery for cyst under [left] arm. Rates pain 8/10 to that area. Discussed safety with transfers. The document failed to</p>		Administrator to ensure procedure is being followed and compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>evidence the patients pain level (8 out of 10) or the patient's verbal report of outpatient surgery was addressed with the physician or case manager.</p> <p>C. The record contained a document dated 11-3-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-3-14 ... Pain Rating '7/10' Pain Area 'stomach' ... Note: 'med set up completed. Assessment and vs completed WNL. No edema noted. Rates stomach pain 7/10. underarm [left] has 4 holes Pt has medication BID to area. discussed using med as directed'" The record failed to evidence the LPN notified the physician or case manager of the patient's change in wound status and pain rating of 7/10.</p> <p>D. The record contained a document dated 11-10-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 11-10-14 ... Note: 'Patient continues topical medication to wound in left axilla per MD order. Moderate serosanguineous drainage [with] odor. After pt. lifted [left] arm to put medicine on, moderate amount of dark blood, thick, from 4 areas.'" The record failed to evidence the RN contacted the physician with the change in wound status.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>E. The record contained a document signed by employee N (registered nurse) on 11/14/14 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? Yes [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank] Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 3 [checked] - daily, but not constantly ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: Yes [checked] Location(s) wound site: 'left axilla' ... Technique: Clean [checked] ... Patient tolerated procedure well: Yes [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location 'Proximal Left axilla' Type: 'abscess' Size: '0.6 x 0.5' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Color Other [checked] Consistency Thick [checked] Wound/Lesion #2 Location '[left] axilla' Type: 'abscess' Size: '0.3 x 0.4' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #3 Location '[left] axilla' Type: 'abscess' Size: '0.4 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked] Wound/Lesion #4 Location 'lateral [left] axilla' Type: 'abscess' Size: '0.7 x 0.7' Odor 'Y' Surrounding Skin 'Red' ... Drainage/Amount Moderate [checked] Color Other [checked] Consistency Thick [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>F. The record contained a document dated 11-24-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '11-24-14' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'Open areas to [left] axilla are now 2, was previously 4 smaller areas. Drainage noted, skin around pink. Pt complains of burning to areas.'" The record failed to evidence the RN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>contacted the physician with the change in wound status.</p> <p>G. The record contained a document dated 12-8-14 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '12-8-14' ... Pain Rating '8/10' Pain Area 'Headache [Left] axilla ... Note: 'Pt. compliant [with] medications thru [through] previous week med set up. ... 1.5 cm x 3.1 cm x 0.2 cm deep [with] no tunneling. Serosanguineous drng [drainage] noted.'" The record failed to evidence the RN contacted the physician with the change in wound status and pain of 8 out of 10.</p> <p>H. The record contained a document dated 12-22-14 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 12-22-14 ... Pain Rating '9/10' Pain Area 'HA [headache]' ... SKIN WNL [checked] ... *Describe rash or wounds in note below including measurements. ... Note: 'med set up completed. Assessment and vs completed WNL. Rates HA 9/10. No edema noted BLE [bilateral lower extremities]. Discussed pt HA's and medication safety'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 9 out of 10.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>I. The record contained a document dated 1-5-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-5-15' ... Pain Rating 6/10 Pain Area 'back /[left] axilla' SKIN ... * Describe rash or wounds in note below including measurements ... Note: 'Pt compliant [with] meds through previous set up. Pt. tolerates visit well. Complains of headache and pain too back and left axilla wound. Wound has foul odor and drainage noted, MD aware.'"</p> <p>The record failed to evidence documentation of physician notification of wound status and pain rating.</p> <p>J. The record contained a document signed by employee N (registered nurse) on 1/12/15 titled "RECERTIFICATION/FOLLOW-UP ASSESSMENT" stating, "Date '11/14/14' Reason for Visit: Recertification [checked] ... [page 3 of 14] PAIN Intensity: (using scales below) Wong-Baker Faces Pain Rating Scale 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse ... Collected Using: 0-10 Scale (subjective reporting) [checked] Is patient experiencing pain? No Problem [checked] ... How does the pain interfere/impact their functional/activity level? (explain) [blank] Pain Assessment Site 1 [blank]"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Site 2 [blank] Site 3 [blank] (M1242) Frequency of pain interfering with patient's active or movement: 2 [checked] - Less often than daily ... [page 5 of 14] INTEGUMENTARY STATUS (Cont'd) ... WOUND CARE: (check all that apply) Wound care done during this visit: No [checked] ... [page 6 of 14] INTEGUMENTARY STATUS (Cont'd) Wound/Lesion #1 Location '[Left] axilla' Type: 'abscess' Size (cm) (LxWxH [length times width times height]): '2.1 cm x 4.6 cm x 0.2 cm' Tunneling [zero] Stage [zero] Odor 'Y' Surrounding Skin 'Intact' Edema 'Y' ... Appearance of the wound bed 'Granulated red' Drainage/Amount Small [checked] Color Serosanguineous [checked] Consistency Thin [checked]" The record failed to evidence the physician was made aware of the patient's change in wound status at time of recertification.</p> <p>K. The record contained a document dated 1-26-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '1-26-15' ... Pain Rating 7/10 Pain Area '[left] Ab [abdominal] fold ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... '[patient] reports MD called [patient] on 1-23-15 and told [patient] to go to the ER to have area on [left] [abdominal] fold drained</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>but said [patient] didn't have a ride and today its too cold'" The record failed to evidence documentation of physician notification of the patient not reporting to the ER for the draining of the abscess.</p> <p>L. The record contained a document dated 2-2-15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date '2-2-15' ... Pain Rating '8/10' Pain Area 'Headache' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: ... 'Pt. tolerates visit well. ... Area has minimal drainage at this time [with] foul odor. Pt. c/o [complains of] tenderness to area. No s/s [signs and symptoms] of infection noted.'" The failed to evidence documentation of physician notification of patient's pain level of 8 out of 10.</p> <p>M. The record contained a document dated 2/9/15 by employee N titled "Nurse Care Visit Note" stating, "Patient Name: [patient #5] Date: '2-9-15' Time in 4:40 p Time Out 5:00 PM ... Pain Rating '8/10' Pain Area: '[left] axilla ... Education Topic: 'Wound Care' ... Skin *describe rash or wounds in note below including measurements. ... Note: 'Pt. compliant [with] all meds through previous set up. Pt. tolerates visit well. Pt seen at wound center today for [left] axilla and [left] groin/abd [abdomen]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>fold. Pt received new order for daily wound care to [left] axilla area. Daily nurse visit to begin 2/10/15 per order. Educated pt. on care to wound area.' ... Nurse Signature [employee N-registered nurse]" The record failed to evidence the physician had been notified of the patient's pain rating of an 8 out of a 0-10 scale.</p> <p>N. The record contained a document dated 2-13-15 by employee J (LPN) titled "Nurse Care Visit Note" stating, "Patient Name [patient #5] Date 2-13-15 ... Pain Rating '7/10' Pain Area '[left] under arm]' ... SKIN ... *Describe rash or wounds in note below including measurements. ... Note: 'measurement obtained to [left] under arm wound. 3x2x.1. Cleansed with normal saline and aquacel applied. assessment and VS WNL. Discussed keeping wound covered'" The record failed to evidence the LPN notified the physician and case manager of the pain level of 7 out of 10.</p> <p>2. On 2/19/15 3:15 PM, employee D (administrator) indicated staff are educated to report increased pain to the physician. The employee indicated being unable to locate documentation of the patient's baseline (tolerable) pain level.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>3. On 2/20/15 at 12:45 PM, an interview with employee N (case manager/registered nurse) was conducted. The employee indicated the patient started services 9/18/14 and upon initial assessment, a wound in the left axillary had been identified. The employee indicated, according to the patient, the wound was evaluated by the physician but no orders for treatment were given. Employee N indicated there was no communication with the physician regarding the evaluation of the wound. The employee indicated at the 11/14/14 recertification assessment, the wound was changed and had become 4 small wounds. The employee indicated being unable to locate documentation in the chart of physician notification of this and indicated being unable to locate documentation the chart evidencing a follow-up had been made. Employee N indicated the wounds had another change and the 4 wounds then become 2. The employee indicated being unable to locate documentation in the record to evidence physician notification. Employee N indicated at the 1/12/14 recertification assessment, the 2 wounds had become 1. The employee indicated on 1/19/15, a second wound on the patient's abdominal fold was discovered at which time the physician was notified and an appointment was scheduled for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>1/21/15. Employee N indicated on 1/21/15, the patient informed the employee of physician contact and of an appointment scheduled to a surgeon to address the wounds on 2/4/15. The employee indicated the patient was directed to go to the ER on 1/23/15 by the physician and have the abscess on the abdominal fold drained but failed to go and the employee indicated being unable to locate documentation in the clinical record of the physician's notification of this.</p> <p>4. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "Plan of Care" states, "POLICY: A written plan of care shall be developed for each client admitted to home care for skilled treatment in consultation with the home health professional staff, the patient's physician, the patient and members of the patient's family. PURPOSE: 1. To ensure delivery of health care services that are medically required for the client. ... PROCEDURE: Plan of Treatment 1. Home health services are furnished to clients under the physician's certification that the services are medically required for the client. ... 2. The plan of care for each patient will include: ... All pertinent diagnoses ... 4. The forms: Oasis Start of Care (initial assessment), Patient medications,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>assessment summary, physician's orders and patient problem list constitute the Plan of Care and are submitted by the case manager and professional team members to the agency within 4 working days of the start of care date. ... 6. RN [registered nurse] case manager, therapists promptly inform the physician of any changes that suggest a need to alter the plan of care. 7. All changes in the plan of care are documented through written and signed physician orders. ... "</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0484" states, "Communications policy and procedure: PURPOSE: To maintain effective communications to assure that all personnel providing services shall appropriately complement on another and support the objectives of the patient's care. POLICY: Communication regarding patient's care shall be documented in the clinical record. ... Field staff will communicate all pertinent information to nursing supervisor and/or nurse case manager of that patient's case. Nursing supervisors will review any new orders with or information with field staff for cases they are working on. The nursing supervisors will promptly alert the physician of any changes that suggest a need to alter the medical plan of care. ... The nursing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>supervisor will notify the patient's physician or other appropriate licensed professional staff and legal representatives, if any, of any significant physical or mental changes observed are reported by the patient. ... "</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "PHYSICIAN ORDERS" states, "POLICY: Every patient will have an individualized plan of care based on the medical, functional and psychosocial needs of each patient. Home care staff shall administer care and treatment according to the specific individualized instructions of the patient;s designated primary physician. ... PURPOSE: ... 2. To facilitate quality improvement in the receipt of physician orders. ... PROCEDURE: 1. Physician orders are initiated when physician or referral source requests skilled services, and required prior any care is initiated, either verbally or in writing. ... 3. Physician verbal or telephone orders for care are recorded and verified by appropriate qualified and licensed professional staff members. ... A. The physician will be notified immediately of any changes in the patient's condition which indicate changes to the plan of treatment. ... Medical Supervision ... 10. The agency will ensure that communication with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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	
N 608 Bldg. 00	<p>physician is timely, appropriate and consistent with the needs of the patient. ... "</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on clinical record review, policy review, and interview, the agency failed to ensure the clinical record contained appropriately authenticated clinical notes in 1 of 10 clinical records reviewed creating the potential to affect all 107 of the agency's patients. (#4)</p>	N 608	All Home Health Aide Daily Notes will be completed in entirety by Home Health Aide completing patient visit. Home health aides will complete hha notes according to the policy titled Home Health Aide Note Completion, Auditing, and	03/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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> <p>1 . Clinical record #4, start of care 6/19/14 and discharge date 8/9/14, evidenced a plan of care for certification period 6/20 to 8/18/14 with orders for home health aide services 12 hours per day, 7 days per week for 60 days. The record contained a physicians order for home health aide services 8 hours per day, 7 days per week.</p> <p>2. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee DD-home health aide] Date 6/24/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Partial bed bath [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... Feeds Self [checked] Encourage Fluids [checked] ACTIVITY LEVEL Up with Assistance [checked] W/C [wheelchair] [checked] Partial Weight Bearing [checked] ... Transfer bed/chair [checked] Transfer toilet [checked] ... ELIMINATION Continent [checked] ... Bedside Commode [checked] ... OTHER ... Medication Reminder [checked] ... HOME MAKING ... Dishes [checked] ... Other: [checked] ... Employee's Signature [employee DD]</p>		<p>Correction Policy which states: Policy: Home Health Aide staff will properly complete documentation according to accepted professional standards and principles that apply to home health documentation . All documentation is to be properly authenticated by the staff member who completes the work <u>only</u> and patient's will sign home health aide documentation confirming that the clock in and out times, the date, and the checked off tasks were completed on that date between those times according to the plan of care. Procedure: Note Completion- 1. When arriving at patient home, HHA will locate company folder and check careplan for tasks to be completed. 2. Next, HHA will document time of arrival at patient home on nurse aide note on appropriate time. This should be the time HHA was scheduled to be there on his or her calendar. 3. Complete tasks and check them off on note as completed according to the home health aide careplan. Only tasks which have been checked off on hha careplan by the Registered Nurse Supervisor or state "prn" in check box should be addressed/completed at this visit and documented on this note. 4. When visit time comes to end per hha schedule, aide should document end time in appropriate line on hha note and sign on hha</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
---	--

(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>Date: '6/24/14' Patient's Signature [name of patient #4] / [signature of employee E-alternate administrator/Director of nursing] Date '6/24/14'."</p> <p>3. The record contained a document titled "Home Health Aide Daily Note" stating, "Patient Name [patient #4] Employee Name [employee EE-home health aide] Date 7/4/14 ... Circle task completed and place a checkmark in the corresponding box: PERSONAL CARE Complete bed bath [checked] Assist-Shower [checked] ... Shampoo Hair [checked] ... Skin Care [checked] ... NUTRITION Prepare Meal [checked] ... HOMEMAKING Light housekeeping [checked] ... Dishes [checked] ... Make bed [checked] Trash [checked] Dusting [checked] Sweeping [checked] ... Employee's Signature [employee E] Date: '7/4/14' Patient's Signature [employee E] Date '7/4/14'."</p> <p>4. On 2/18/15 at 3 PM, employee E indicated the patient had orders for home health aide services 8 hours per day, 7 days per week and the aide frequency was 2 times per day, 4 hours per visit. The employee indicated he/she reviews the aide's documentation of the visit and if something is wrong with the document, he/she corrects it. The employee</p>		<p>signature line and date line next to it. When signing aide is confirming he/she completed the tasks checked as being completed on that date between the in and out time documented and confirming these were completed in accordance with the HHA careplan. 5. The hha should then request for the patient/or patient family to sign his/her own name on the patient/family signature line and remind them that by doing so they are confirming that the aide was at their home, between the documented times and completed the checked off tasks that were completed in accordance with the hha careplan that the patient was active in helping develop for his/her own care. The patient should also document the date on the date line next to his/her signature. Auditing and Corrections of HHA note- 1. Kokomo HHAs are to turn their notes in each day after their visits are complete. There is a drop box located at the front door of the office building in kokomo. In areas other than Kokomo, a courier is assigned to pick up notes and HHA will be oriented to this when beginning employment. 2. When HHAs turn in notes, they will first be verified in the computer program for time, date and completion of visit. If notes do not match schedule, a copy will be made and forwarded to HR for counseling of scheduler and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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>indicated the 7/4/14 aide visit was performed by employee EE but there must have been something wrong with the aides documentation because employee E had to re-write it. Employee E stated, "I did not make the visit, [name of employee EE] did but there must have been something wrong with the document so I re-did it." Employee E indicated he/she should have wrote employee EE's name where the document states, "Employee's Signature." The employee indicated being unsure of how many times this has occurred.</p> <p>5. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled, "CLINICAL RECORDS -PURPOSE AND CONTENT" state, "PROCEDURE: Records are documented using professional standards and will contain the following: ... 7. Signed and dated clinical notes for each contact which are written the day of service and incorporated into the patient's clinical record at least weekly."</p> <p>6. The policy with an effective date of 7/20/12 and a reviewed date as 7/25/14 titled "N0608" states, "POLICY: Clinical chart order and closed chart order and retention. ... The clinical record will contain pertinent past and current findings in accordance with accepted</p>		<p>home health aide. 3. Notes will be audited before filed into the patient record for correctness including: completion in black ink only, tasks completed compared to HHA careplan, and confirmation signatures. Auditor nor anyone in the office will make any type of alteration on the home health aide note If notes do not match careplan, are in another color of ink a copy will be made and the copy will be sent to HR for counseling of home health aide. If a signature is missing, the note will be given to the scheduler, the scheduler will contact the home health aide, and the home health aide will be required to get the proper signatures to authenticate the note within 24 hours or a copy will be made of the note and giving to HR for counseling/disciplinary service and visit for that note will not be billed. 4. If a home health aide writes the wrong information down during a visit and realizes it during the visit, he or she is to put one line through the incorrect information, write "error" above it, and include date, time and their initials. If these are not completed correctly, auditor will again make a copy of the note and send to HR for HHA counseling. HR to track disciplinary form on employees. Mandatory In Service to be completed by every Home health Aide on proper home health aide daily note completion. The</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2015
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
(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	
	professional standards shall be maintained for every patient as follows. ... All entries must be legible, clear, complete and appropriately authenticated and dated. Authentications must include signatures or a secured computer entry."		Administrator oversees the nurse management staff and has inserviced the Nursing Supervisor/Alt Administrator and all nurse management staff on the HHA note completion policy and has instructed them that immediate termination would be the consequence of violating this policy. HR to track all attendance of mandatory in service to ensure all appropriate staff present. Administrator to instruct in service and provide documented minutes. HR employees to keep all in service tracking documentation and provide upon request. HR to discipline through write up process, any staff that does not complete in service. Non compliant Home Health Aides will not be given scheduled patient visit hours until mandatory in service information has been received. The Administrator will be responsible for completing the correction of this deficiency and preventing this deficiency from recurring in the future.		