

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2015
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NAME OF PROVIDER OR SUPPLIER HOME SERVICES UNLIMITED INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7750 N MICHIGAN RD INDIANAPOLIS, IN 46268
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G000000	<p>This was a federal home health agency complaint investigation survey.</p> <p>Complaint # IN00159601 - Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Survey Dates: 1/20 - 26/15</p> <p>Facility #: 009865</p> <p>Medicaid #: 200122510A</p> <p>Surveyor: Deborah Franco RN, PHNS</p> <p>Census: 148 active skilled nursing patients 35 active home health aide only patients 183 total</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 30, 2015</p>	G000000		
G000144	484.14(g)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on policy review, review of clinical records, and interview, the agency failed to ensure the agency personnel maintained timely liaison to ensure their efforts coordinated efficiently and supported the objectives in the patient plan of care with another agency providing services for 1 of 3 wound care patients records reviewed (1).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency policy "Coordination of Care", copyright 2014 by Suedkamp Enterprise, states, "Coordination of care is an ongoing process among personnel providing care and other team members. Coordination efforts should be effectively coordinated and support the outcomes and goals identified in the plan of care and then recorded in the clinical record ... The clinical record should contain documentation of effective interchange, reporting, and coordination of patient care ... Coordination efforts also include the physician and other agencies involved." Clinical Record (CR) 1, start of care 	G000144	<p>The Administrator in-serviced Clinicians that agency personnel must maintain timely liaison to ensure that efforts are coordinated efficiently and support the objectives in the patients Plan of Care with any other agency providing care Coordination of care should be ongoing guiding personnel providing care and other team members. Efforts should be effectively coordinated and support outcomes and goals identified in the plan of care and recorded in the clinical record.</p> <p>The clinical record should contain documentation of effective interchange, reporting, and coordination of care Coordination efforts also include the physician and other agencies involved</p> <p>Ten percent of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard G144 and the agency policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	02/06/2015

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	<p>(SOC) 3-4-14, diagnoses included pneumonia, methicillin resistant staph aureus, varicose ulcer of lower extremity, diabetes mellitus type 2, dysphagia, mild mental retardation, anemia, osteoporosis, and gastrostomy as identified in the plan of care (POC) for certification period 8-31 to 10-29-14. The skilled nursing (SN) goal for the certification period was "Wounds will heal without Complications within cert. period." Patient lived in a residential home with 2 other developmentally delayed patients.</p> <p>A. Patient 1 received SN services 3 times each week to include wound care to right and left lower leg venous stasis ulcers.</p> <p>B. Patient 1 was also receiving 24 hour a day attendant care services from another agency.</p> <p>C. The clinical record failed to evidence the agency maintained liaison with the agency providing 24 hour a day attendant care services which effectively coordinated their efforts to support the objectives in the patient's plan of care.</p> <p>3. During home visit of patient 10, on 1-23-15 at 10:45 AM, start of care 12-20-14, whose clinical record included a plan of care for the certification period</p>			

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G000175	<p>of 12-20-14 to 2-17-15 with orders for services from skilled nursing, physical therapy, and occupational therapy, the patient indicated she received attendant care services from another agency. The clinical record failed to evidence documentation of coordination of care between this agency and the agency providing attendant care services.</p> <p>4. On 1-26-15 at 3:30 PM, Employee E indicated there were no case conference minutes for the patients 1 and 10 to show coordination of care between the 2 agencies.</p> <p>5. On 1-26-15 at 3:45, Employee B, Nursing Supervisor, indicated the clinical record failed to evidence communication and interventions were effectively coordinated and implemented.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record review and interview, the agency failed to ensure the registered nurse address the accumulation of flies in the patient's home for 1 of 3 patients who were receiving wound care. (#1)</p>	G000175	The Administrator in-serviced nurses on responsibilities of Registered Nurse to ensure that nurses initiate appropriate preventive and rehabilitative nursing procedures (eg. accumulation of flies in patient's home should be addressed immediately and efforts	02/06/2015

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G000176	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 1 identified the patient was sent to the emergency room by the skilled nurse, employee D on 9-7-14 for treatment of larvae in the right leg dressing. The patient had venous stasis ulcers for which the agency was providing wound care. Flies had been observed in the patient's room by Employee D on 9-5-14, and flies had landed on the removed dressing and on the legs during the dressing change. 2. Flies were also observed in the patient's room on 9-24-14 by Employee D but did not contaminate the wound. 3. On 1-26-15 at 3:45, Employee B, Nursing Supervisor, indicated the patient's home environment issue was resolved 10-8-14 when the attendant care agency made a comprehensive review of the home, implemented additional interventions, and educated attendant caregiver staff regarding the maintaining a safe and healthy home environment for patients. <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and</p>		<p>coordinated with all parties involved in care of patient to ensure flies are out of patient's home ASAP). Efforts should be documented in the patient record. 10% of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard G175 and the agency policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>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 and interview, the agency failed to ensure the skilled nurse, Employee D, notified the physician of a change in patient's condition for 1 of 3 wound care patients whose clinical records were reviewed (1).</p> <p>Finding include:</p> <p>1. Clinical Record 1, start of care 3-4-14, contained a plan of care for certification period 8-31 to 10-29-14. Patient 1 received SN services 3 times each week to include wound care to right and left lower leg venous stasis ulcers. Patient 1 was sent to the emergency room by SN Employee D on 9-7-14 for treatment of larvae in the right leg dressing. The clinical record failed to evidence the agency notified the attending physician of this change in patient's condition.</p> <p>2. On 1-26-15 at 3:45 PM, Employee B indicated the agency expectation is that the physician will be notified when a change in the patient's condition necessitates an Emergency Room visit and this did not occur.</p>	G000176	<p>The Administrator in-serviced nurses that it is the responsibility of the RN to prepare clinical and progress notes, coordinate services, inform the physician and other personnel of changes in the patient's condition and needs. Clinical record will show evidence that attending physician was notified of the change in patient's condition.</p> <p>Ten percent of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard G176 and the agency policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	02/06/2015

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N000000	<p>This was a state home health agency complaint investigation survey.</p> <p>Complaint # IN00159601 - Substantiated: State deficiencies related to the allegation are cited. An unrelated deficiency was also cited.</p> <p>Survey Dates: 1/20 - 26/15</p> <p>Facility #: 009865</p> <p>Medicaid #: 200122510A</p> <p>Surveyor: Deborah Franco RN, PHNS</p> <p>Census: 148 active skilled nursing patients 35 active home health aide only patients 183 total</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 30, 2015</p>	N000000		

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N000486	<p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on policy review, review of clinical records, and interview, the agency failed to ensure the agency personnel maintained timely liaison to ensure their efforts coordinated efficiently and supported the objectives in the patient plan of care with another agency providing services for 1 of 3 wound care patients records reviewed (1).</p> <p>Findings include:</p> <p>1. Agency policy "Coordination of Care", copyright 2014 by Suedkamp Enterprise, states, "Coordination of care is an ongoing process among personnel providing care and other team members. Coordination efforts should be effectively coordinated and support the outcomes and goals identified in the plan of care and then recorded in the clinical record ... The clinical record should contain documentation of effective interchange, reporting, and coordination of patient care ... Coordination efforts also include the physician and other agencies</p>	N000486	<p>Administrator retrained nursing staff that the home health agency's personnel shall coordinate its services with other health or social services providers serving the patient to ensure that clinicians maintain timely liaison to efficiently coordinate their efforts and support the objectives in the patient's Plan of Care. Coordination efforts and interventions will be documented in the patient's record.</p> <p>Ten percent of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard N486 and the agency policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	02/06/2015

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	<p>involved."</p> <p>2. Clinical Record (CR) 1, start of care (SOC) 3-4-14, diagnoses included pneumonia, methicillin resistant staph aureus, varicose ulcer of lower extremity, diabetes mellitus type 2, dysphagia, mild mental retardation, anemia, osteoporosis, and gastrostomy as identified in the plan of care (POC) for certification period 8-31 to 10-29-14. The skilled nursing (SN) goal for the certification period was "Wounds will heal without Complications within cert. period." Patient lived in a residential home with 2 other developmentally delayed patients.</p> <p>A. Patient 1 received SN services 3 times each week to include wound care to right and left lower leg venous stasis ulcers.</p> <p>B. Patient 1 was also receiving 24 hour a day attendant care services from another agency.</p> <p>C. The clinical record failed to evidence the agency maintained liaison with the agency providing 24 hour a day attendant care services which effectively coordinated their efforts to support the objectives in the patient's plan of care.</p> <p>3. During home visit of patient 10, on</p>			

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N000543	<p>1-23-15 at 10:45 AM, start of care 12-20-14, whose clinical record included a plan of care for the certification period of 12-20-14 to 2-17-15 with orders for services from skilled nursing, physical therapy, and occupational therapy, the patient indicated she received attendant care services from another agency. The clinical record failed to evidence documentation of coordination of care between this agency and the agency providing attendant care services.</p> <p>4. On 1-26-15 at 3:30 PM, Employee E indicated there were no case conference minutes for the patients 1 and 10 to show coordination of care between the 2 agencies.</p> <p>5. On 1-26-15 at 3:45, Employee B, Nursing Supervisor, indicated the clinical record failed to evidence communication and interventions were effectively coordinated and implemented.</p> <p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures.</p>	N000543	Administrator retrained the	02/06/2015			

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	<p>Based on clinical record review and interview, the agency failed to ensure the registered nurse addressed the accumulation of flies in the patient's home for 1 of 3 patients who were receiving wound care. (#1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 1 identified the patient was sent to the emergency room by the skilled nurse, employee D on 9-7-14 for treatment of larvae in the right leg dressing. The patient had venous stasis ulcers for which the agency was providing wound care. Flies had been observed in the patient's room by Employee D on 9-5-14, and flies had landed on the removed dressing and on the legs during the dressing change. 2. Flies were also observed in the patient's room on 9-24-14 by Employee D but did not contaminate the wound. 3. On 1-26-15 at 3:45, Employee B, Nursing Supervisor, indicated the patient's home environment issue was resolved 10-8-14 when the attendant care agency made a comprehensive review of the home, implemented additional interventions, and educated attendant caregiver staff regarding the maintaining a safe and healthy home environment for 		<p>nurses that the registered nurse (except where services are limited to Therapy-only) shall: initiate appropriate preventive and rehabilitative nursing procedures.</p> <p>If a situation occurs that could affect the care of the patient the registered nurse shall immediately address the situation and coordinate efforts with other agency to insure the situation is rectified immediately. The documentation in the patient record should show evidence of nurse's efforts. 10% of all clinical records will be audited quarterly for evidence that coordination of care is provided and documented in accordance with Standard N543 and the HSU policy on "Coordination of Care." The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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N000546	<p>patients.</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the skilled nurse, Employee D, notified the physician of a change in patient's condition for 1 of 3 wound care patients whose clinical records were reviewed (1).</p> <p>Finding include:</p> <p>1. Clinical Record 1, start of care 3-4-14, contained a plan of care for certification period 8-31 to 10-29-14. Patient 1 received SN services 3 times each week to include wound care to right and left lower leg venous stasis ulcers. Patient 1 was sent to the emergency room by SN Employee D on 9-7-14 for treatment of larvae in the right leg dressing. The clinical record failed to evidence the</p>	N000546	<p>Administrator retrained nurses that the registered nurse must inform physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family, meeting the nursing related needs, participate in in-service programs and supervise and teach other nursing personnel, with the exception where services are limited to therapy only. 10% of all clinical records will be audited quarterly for evidence of documentation that nurses are notifying physicians of changes in patients' condition. The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	02/06/2015			

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	<p>agency notified the attending physician of this change in patient's condition.</p> <p>2. On 1-26-15 at 3:45 PM, Employee B indicated the agency expectation is that the physician will be notified when a change in the patient's condition necessitates an Emergency Room visit and this did not occur.</p>				