

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
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NAME OF PROVIDER OR SUPPLIER PEDIATRIC PLUS HOME HEALTHCARE SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 925 MAIN STREET JEFFERSONVILLE, IN 47130
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G000000	This visit was a home health agency federal recertification survey. Survey Dates: January 21, 22, 23, and 24, 2014 Facility #: 012370 Medicaid Vendor #: 201008780A Surveyor: Susan E. Sparks, RN, PHNS Skilled Patients 18 Home Health Aide Patients 1 Total 19 Quality Review: Joyce Elder, MSN, BSN, RN January 30, 2014	G000000		
G000121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation and interview, the agency failed to ensure staff followed accepted professional standards in 1 of 3 home visits with the potential to affect all 19 patients. (#5) Findings:	G000121	The noted citations have been or will be corrected in the following manner to ensure our staff follow acceptable professional standards. 1) Employee D was re-educated on the proper utilization of using a three point restraint and on reporting malfunctions or needed repairs on equipment. The	02/14/2014

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>1. On 1/22/14 at 9:50 AM a home visit was made to Patient # 5 with the Director of Nursing (DON) and Assistant Director of Nursing (ADON). The patient is a non ambulatory, non verbal child with no intentional muscle movement. Patient was observed on the floor. The LPN (licensed practical nurse), Employee D, picked the patient up and placed the patient in a wheelchair. The LPN secured the safety device between the thighs and attached one side of the three point chest restraint. The left side side clip was broken and would not attach. The patient likes to chew on the broken clip because of the hardness. There is a soft chew toy attached to the chair but the patient will not redirect to the soft toy. The ADON found a hard chew toy for the patient and instructed the LPN to put the tray on the chair. With the tray on, the patient still prefers the clip but with persistence was redirected to the hard chew toy. The LPN went to a chair across the room and sat down and let the ADON redirect the patient. The patient has a 16 Fr. 1.5 CM J/G Mic-Key Button gastronomy tube for feedings. There was formula from the previous feeding in the tubing and bag. The LPN connected the tubing without cleaning either end, cleaning her hands, or wearing gloves. She then opened a new</p>		<p>broken clip to the restraint has been replaced. Employee D was re-educated on acceptable techniques to use when trying to redirect a client. Employee D was reminded of professional standards when in a client's home. Employee D was re-educated on acceptable infection control practices regarding cleaning and re-use of feeding bags; cleaning of the male and female parts of tubing before connecting, and re-education on when to wash hands and when and to wear gloves. Since all clients have the potential to be affected by this citing, a memo will be sent out to all staff reminding them to follow acceptable professional standards while in a client's home. 2) To ensure this citing does not recur, the ADON and Clinical Supervisor will visit the client every 2 weeks times 1 month to observe for compliance and then monthly thereafter with observations being documented and all other nursing staff will be monitored for compliance during monthly visits. 3) The DON will review documentation of visits to ensure Employee D is following client as needed and acceptable Professional standards being followed.</p>				

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	<p>container of formula and poured it into the bag with the old formula. The LPN then returned to the chair across the room and put her feet up. The patient started to chew on the clip again and the ADON got up and redirected with the hard chew toy.</p> <p>2. On 1/22/14 at 11 AM, the DON, Employee A, indicated she would have expected to see the LPN cleanse her hands, cleanse the tubing, and wear gloves. She did not know the clip was broken, and, even if dad did fix these things, they needed to take care of the broken clip so the patient wouldn't chew on it and there would be no chance the patient would slip from the chair. She would have expected the LPN to be the one up and redirecting the child with a different hard chew toy and to find a solution to the clip.</p> <p>3. On 1/24/14 at 11:00 AM, the Administrator, Employee B, indicated the agency does not have any policies for control of communicable diseases. They have adopted some books to use as guidelines but nothing specific to their specific clients.</p>				

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record review and interview, the agency failed to ensure treatments and visits were made as ordered in the patient's plan of care in 7 of 11 clinical records reviewed with the potential to affect all 19 patients. (1, 3, 4, 5, 6, 10 and 11) Findings: 1. Clinical record 1, start of care (SOC) 8/8/12, evidenced physician orders for the certification period 11/24/13 through 1/22/14 for 9 hours of skilled nursing Monday through Friday for a total of skilled nursing hours of 45 per week. Patient receives 60 hours respite per month. The nurse is to perform "Cough Assist (CA): Skilled Nurse (SN) to administer cough assist as ordered. ... Chest Percussion Vest (CP): Vest is noted to be pre-programmed. SN to utilize Program ... SN to utilize morning and night before client goes to bed. ... SN to perform straight catheterization of the client's bladder 2-3 times daily per clean technique."</p>	G000158	<p>1) The agency is reviewing all clients plan of care and Medicaid prior authorizations and waiver hours and writing addendums to the plan of care to ensure services are provided accordingly. Client's schedules have been revised to reflect clarifications in each client's plan of care addendum. Clinical record 1 regarding "Cough Assist" and "Chest Percussion Vest" are listed on the MAR/Treatment Record and documented. The straight cath order has been changed to 2-3 times daily PRN per clean technique if patients I & O vary, etc. The variance in hours for clinical record 3 has been clarified as noted in step 1 of G158. Clinical record 4, g-tube placement check and residual check are on the MAR/Treatment record. Nursing staff have been informed to follow physician's order regarding placement and residual and document findings on the MAR. G-tube flush is on the MAR and nursing is documenting. Nursing staff are being reminded in Memo form to document flushes in the Intake section of the Patient's Flow Record (nursing note). Clinical record 5 client PT/OT</p>	02/14/2014			

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	<p>A. The clinical record failed to evidence CA and CP on 11/28/13, 12/6/13, 12/13/13, 12/19/13, and 12/25/13. The clinical record failed to evidence straight catheterization of the client's bladder 2-3 times daily per clean technique at any time.</p> <p>B. On 1/24/14 at 1 PM the Director of Nursing (DON), Employee A, indicated these services had not been performed as ordered.</p> <p>2. Clinical record 3, SOC 10/22/13, evidenced physician orders for the certification period 10/20/13 through 12/18/13 for services 5 days a week for 8 hours a day.</p> <p>A. The clinical record evidenced 12 hours 10/21/13, 10/23/13, 10/28/13, 10/30/13, 11/4/13, 11/6/13, 11/11/13, 11/13/12, 11/18/13, 11/20/13, 11/22/13, 11/25/13, 12/2/13, 12/4/13, 12/9/13, 12/11/13, 12/16/13, and 12/18/13.</p> <p>B. The clinical record evidenced 10 hours 10/22/13, 10/24/13, 10/25/13, 10/29/13, 10/31/13, 11/1/13, 11/5/13, 10/7/13, 10/8/13, 11/12/13, 11/14/13, 11/15/13, 11/19/13, 11/21/13, 11/22/13, 11/26/13, 11/29/13, 12/3/13, 12/5/13, 12/6/13, 12/10/13, 12/12/13, 12/13/13, 12/17/13, and 10 hours 12/19/13.</p>		<p>recommendation for in the home has been requested. PT/OT to re-evaluate client due to current hand splint not fitting properly. An order has been obtained for PT/OT to evaluate and size for hand splint. Once the splint is obtained a copy of PT/OT recommendations and will be placed it on the MAR/Treatment Record for nursing to follow and document. Clients of clinical record 6 and 11 corrections are included in G158 step 1. 2) During clinical supervisory visit's every 2 weeks times 1 month and then monthly thereafter the patient will be monitored to ensure application of splint is followed per PT/OT recommendations and documented. Patient Flow Record and MAR will be reviewed weekly by Medical Records Designee to ensure compliance.</p>	

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	<p>C. The clinical record evidenced 0 hours on 11/27/13 and 11/28/13.</p> <p>D. On 1/24/14 at 1:15 PM, the DON, Employee A, indicated hours provided were not as ordered.</p> <p>3. Clinical record 4, SOC 7/1/12, evidenced physician orders for the certification period 10/25/13 through 12/23/13 for the SN to "check placement of G-tube. SN to check for residual if greater than 50 ml,"</p> <p>A. The clinical record failed to evidence checking G-tube placements, flushing of G-tube before and after feeding, and checking for residual on 10/24/13, 10/25/13, 10/26/13, 10/27/13, 10/28/13, 10/30/13, 10/31/13, 11/2/13, 11/3/13, 11/4/13, 11/5/13, 11/6/13, 11/7/13, 11/8/13, 11/9/13, 11/10/13, 11/11/13, 11/12/13, 11/13/13, 11/14/13, 11/16/13, 11/17/13, 11/18/13, 11/20/13, 11/21/13, 11/22/13, 11/23/13, 11/24/13, 11/25/13, 11/26/13, 11/27/13, 11/28/13, 11/30/13, 12/1/13, 12/2/13, 12/3/13, 12/4/13, 12/5/13, 12/6/13, 12/7/13, 12/8/13, 12/9/13, 12/11/13, 12/12/13, 12/13/13, 12/14/13, 12/15/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/22/13, and 12/23/13.</p>						

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	<p>B. The clinical record failed to evidence checking G-tube placements and flushing of G-tube before and after feeding on 10/29/13, 11/11/13, 11/15/13, 11/19/13, 11/29/13 ,12/10/13 and 12/13/13.</p> <p>C. On 1/24/14 at 1:25 PM, the DON, Employee A, indicated the services were not performed as ordered.</p> <p>4. Clinical record 5, SOC 5/8/13, evidenced physician orders for the certification period 10/24/13 through 12/22/13 for 37.5 hours per week with SN to follow PT (physical therapist) / OT (occupational therapist) recommendations per treatment plan present in the client's home. SN to apply hand splint to the client's left arm, on for two hours and off for two hours, for up to eight hours a day.</p> <p>A. The clinical record failed to evidence 37.5 hours week 1, week 2, week 3, week 4, week 5, week 7, week 8, and week 9.</p> <p>B. The clinical record failed to evidence a PT/OT therapist treatment plan was available for personnel to follow.</p> <p>C. The clinical record failed to</p>			

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	<p>evidence the SN applied the hand splint to the client's left arm on 10/25/13, 10/28/13, 10/29/13, 10/30/13, 10/31/13, 11/1/13, 11/2/13, 11/4/13, 11/5/13, 11/6/13, 11/7/13, 11/8/13, 11/11/13, 11/12/13, 11/13/13, 11/14/14, 11/15/13, 11/18/13, 11/19/13, 11/20/13, 11/21/13, 11/22/13, 11/25/13, 11/26/13, 11/26/13, 11/29/13, 12/2/13, 12/3/13/, 12/4/13, 12/5/13, 12/6/13, 12/7/13, 12/9/13, 12/10/13, 12/11/13, 12/12/13, 12/13/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/21/13, and 12/22/13.</p> <p>D. On 1/24/14 at 1:30 PM, the DON, Employee A, indicated the services were not performed as ordered.</p> <p>5. Clinical record 6, SOC 4/29/13, evidenced physician orders for the certification period 10/26/13 through 12/24/13 for client to receive home health aide (HHA) services funded through Medicaid PA for visits of 40 hours per week.</p> <p>A. The clinical record failed to evidence 40 hours week 1, week 2, week 3, week 4, week 5, week 6, week 7, week 8, and week 9.</p> <p>B. On 1/24/14 at 1: 35 PM, the DON, Employee A, indicated the hours were not as ordered.</p>			

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G000170	<p>6. Clinical record 10, SOC 11/26/12, evidenced physician orders for the certification period 11/23/13 through 1/21/14 for client to receive respite up to 5 hours a day 2 days a week.</p> <p>A. The clinical record evidenced three days week 4 and week 9.</p> <p>B. On 1/24/14 at 1:50 PM, the DON indicated the visits were incorrect.</p> <p>7. Clinical record 11, SOC 4/16/12, evidenced physician orders for the certification period 12/6/13 through 2/3/14 for client to receive services 9 hours a day 6 days a week.</p> <p>A. The clinical record fails to evidence 6 days during week 2 and week 4.</p> <p>B. On 1/24/14 at 2:00 PM the DON Employee A indicated the visits were incorrect.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review and interview the agency failed to ensure their personnel provided skilled nursing services according to physician orders in the patient's plan of care in 6 of 11</p>	G000170	Administrator purchased a Policy and Procedure Manual for Home Health to include Infection Control Measures. 1) 1) The agency is reviewing all clients plan of care and Medicaid prior authorizations	02/14/2014

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	<p>clinical records reviewed with the potential to affect all 19 patients. (1, 3, 4, 5, 10, and 11)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 8/8/12, evidenced physician orders for the certification period 11/24/13 through 1/22/14 for 9 hours of skilled nursing Monday through Friday for a total of skilled nursing hours of 45 per week. Patient receives 60 hours respite per month. The nurse is to perform "Cough Assist (CA): Skilled Nurse (SN) to administer cough assist as ordered. ... Chest Percussion Vest (CP): Vest is noted to be pre-programmed. SN to utilize Program ... SN to utilize morning and night before client goes to bed. ... SN to perform straight catheterization of the client's bladder 2-3 times daily per clean technique."</p> <p>A. The clinical record failed to evidence CA and CP on 11/28/13, 12/6/13, 12/13/13, 12/19/13, and 12/25/13. The clinical record failed to evidence straight catheterization of the client's bladder 2-3 times daily per clean technique at any time.</p> <p>B. On 1/24/14 at 1 PM the Director of Nursing (DON), Employee A,</p>		<p>and waiver hours and writing addendums to the plan of care to ensure services are provided accordingly. Client's schedules have been revised to reflect clarifications in each client's plan of care addendum. Clinical record 1, regarding "Cough Assist" and "Chest Percussion Vest" are listed on the MAR/Treatment Record and documented. The straight cath order has been changed to 2-3 times daily PRN per clean technique if patients I & O vary, etc. The variance in hours for clinical record 3, has been clarified as noted in step 1 of G158. Clinical record 4, g-tube placement check and residual check are on the MAR/Treatment record. Nursing staff have been informed to follow physician's order regarding placement and residual and document findings on the MAR. G-tube flush is on the MAR and nursing is documenting. Nursing staff are being reminded in Memo form to document flushes in the Intake section of the Patient's Flow Record (nursing note). Clinical record 5 client PT/OT recommendation for in the home has been requested. PT/OT to re-evaluate client due to current hand splint not fitting properly. An order has been obtained for PT/OT to evaluate and size for hand splint. Once the splint is obtained a copy of PT/OT recommendations and will be</p>				

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	<p>indicated these services had not been performed as ordered.</p> <p>2. Clinical record 3, SOC 10/22/13, evidenced physician orders for the certification period 10/20/13 through 12/18/13 for SN services 5 days a week for 8 hours a day.</p> <p>A. The clinical record evidenced 12 hours 10/21/13, 10/23/13, 10/28/13, 10/30/13, 11/4/13, 11/6/13, 11/11/13, 11/13/12, 11/18/13, 11/20/13, 11/22/13, 11/25/13, 12/2/13, 12/4/13, 12/9/13, 12/11/13, 12/16/13, and 12/18/13.</p> <p>B. The clinical record evidenced 10 hours 10/22/13, 10/24/13, 10/25/13, 10/29/13, 10/31/13, 11/1/13, 11/5/13, 10/7/13, 10/8/13, 11/12/13, 11/14/13, 11/15/13, 11/19/13, 11/21/13, 11/22/13, 11/26/13, 11/29/13, 12/3/13, 12/5/13, 12/6/13, 12/10/13, 12/12/13, 12/13/13, 12/17/13, and 10 hours 12/19/13.</p> <p>C. The clinical record evidenced 0 hours on 11/27/13 and 11/28/13.</p> <p>D. On 1/24/14 at 1:15 PM, the DON, Employee A, indicated hours provided were not as ordered.</p> <p>3. Clinical record 4, SOC 7/1/12, evidenced physician orders for the</p>		<p>placed it on the MAR/Treatment Record for nursing to follow and document. Clients of clinical record 10 and 11 corrections are included in G158 step 1. 2) During clinical supervisory visit for Clinical Record 5 client, will be every 2 weeks times 1 month and then monthly thereafter the patient will be monitored to ensure application of splint is followed per PT/OT recommendations and documented and that infection control practices are being followed. Patient Flow Record and MAR will be reviewed weekly by Medical Records Designee to ensure compliance. During monthly clinical supervisory visits each client will be monitored while care is being provided to ensure Infection Control Standards are being followed. Documentation of observations will be documented. The DON will review Clinical Supervisory documentation to ensure compliance is maintained per the plan of care for each client.</p>		

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	<p>certification period 10/25/13 through 12/23/13 for the SN to "check placement of G-tube. SN to check for residual if greater than 50 ml,"</p> <p>A. The clinical record failed to evidence checking G-tube placements, flushing of G-tube before and after feeding, and checking for residual on 10/24/13, 10/25/13, 10/26/13, 10/27/13, 10/28/13, 10/30/13, 10/31/13, 11/2/13, 11/3/13, 11/4/13, 11/5/13, 11/6/13, 11/7/13, 11/8/13, 11/9/13, 11/10/13, 11/11/13, 11/12/13, 11/13/13, 11/14/13, 11/16/13, 11/17/13, 11/18/13, 11/20/13, 11/21/13, 11/22/13, 11/23/13, 11/24/13, 11/25/13, 11/26/13, 11/27/13, 11/28/13, 11/30/13, 12/1/13, 12/2/13, 12/3/13, 12/4/13, 12/5/13, 12/6/13, 12/7/13, 12/8/13, 12/9/13, 12/11/13, 12/12/13, 12/13/13, 12/14/13, 12/15/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/22/13, and 12/23/13.</p> <p>B. The clinical record failed to evidence checking G-tube placements and flushing of G-tube before and after feeding on 10/29/13, 11/11/13, 11/15/13, 11/19/13, 11/29/13 ,12/10/13 and 12/13/13.</p> <p>C. On 1/24/14 at 1:25 PM, the DON, Employee A, indicated the services were not performed as ordered.</p>						

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	<p>4. Clinical record 5, SOC 5/8/13, evidenced physician orders for the certification period 10/24/13 through 12/22/13 for 37.5 hours per week with SN to follow PT (physical therapist) / OT (occupational therapist) recommendations per treatment plan present in the client's home. SN to apply hand splint to the client's left arm, on for two hours and off for two hours, for up to eight hours a day.</p> <p>A. The clinical record failed to evidence 37.5 hours week 1, week 2, week 3, week 4, week 5, week 7, week 8, and week 9.</p> <p>B. The clinical record failed to evidence a PT/OT therapist treatment plan was available for personnel to follow.</p> <p>C. The clinical record failed to evidence the SN applied the hand splint to the client's left arm on 10/25/13, 10/28/13, 10/29/13, 10/30/13, 10/31/13, 11/1/13, 11/2/13, 11/4/13, 11/5/13, 11/6/13, 11/7/13, 11/8/13, 11/11/13, 11/12/13, 11/13/13, 11/14/14, 11/15/13, 11/18/13, 11/19/13, 11/20/13, 11/21/13, 11/22/13, 11/25/13, 11/26/13, 11/26/13, 11/29/13, 12/2/13, 12/3/13/, 12/4/13, 12/5/13, 12/6/13, 12/7/13, 12/9/13,</p>						

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	<p>12/10/13, 12/11/13, 12/12/13, 12/13/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/21/13, and 12/22/13.</p> <p>D. On 1/24/14 at 1:30 PM, the DON, Employee A, indicated the services were not performed as ordered.</p> <p>5. Clinical record 10, SOC 11/26/12, evidenced physician orders for the certification period 11/23/13 through 1/21/14 for client to receive respite up to 5 hours a day 2 days a week.</p> <p>A. The clinical record evidenced three days week 4 and week 9.</p> <p>B. On 1/24/14 at 1:50 PM, the DON indicated the visits were incorrect.</p> <p>6. Clinical record 11, SOC 4/16/12, evidenced physician orders for the certification period 12/6/13 through 2/3/14 for client to receive SN services 9 hours a day 6 days a week.</p> <p>A. The clinical record fails to evidence 6 days during week 2 and week 4.</p> <p>B. On 1/24/14 at 2:00 PM the DON Employee A indicated the visits were incorrect.</p>						

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N000000	<p>This visit was a home health agency state licensure survey.</p> <p>Survey Dates: January 21, 22, 23, and 24, 2014</p> <p>Facility #: 012370</p> <p>Medicaid Vendor #: 201008780A</p> <p>Surveyor: Susan E. Sparks, RN, PHNS</p> <p>Skilled Patients 18 Home Health Aide Patients 1 Total 19</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 30, 2014</p>			N000000			
N000470	<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 interview, the agency failed to have policies and procedures for the control of communicable diseases for 1</p>			N000470	<p>Administrator purchased a Policy and Procedure Manual for Home Health to include Infection Control</p>		02/14/2014

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	<p>skilled nursing hours of 45 per week. Patient receives 60 hours respite per month. The nurse is to perform "Cough Assist (CA): Skilled Nurse (SN) to administer cough assist as ordered. ... Chest Percussion Vest (CP): Vest is noted to be pre-programmed. SN to utilize Program ... SN to utilize morning and night before client goes to bed. ... SN to perform straight catheterization of the client's bladder 2-3 times daily per clean technique."</p> <p>A. The clinical record failed to evidence CA and CP on 11/28/13, 12/6/13, 12/13/13, 12/19/13, and 12/25/13. The clinical record failed to evidence straight catheterization of the client's bladder 2-3 times daily per clean technique at any time.</p> <p>B. On 1/24/14 at 1 PM the Director of Nursing (DON), Employee A, indicated these services had not been performed as ordered.</p> <p>2. Clinical record 3, SOC 10/22/13, evidenced physician orders for the certification period 10/20/13 through 12/18/13 for services 5 days a week for 8 hours a day.</p> <p>A. The clinical record evidenced 12 hours 10/21/13, 10/23/13, 10/28/13,</p>		<p>etc. Clinical record 4, g-tube placement check and residual check are on the MAR/Treatment record. Nursing staff have been informed to follow physician's order regarding placement and residual and document findings on the MAR. G-tube flush is on the MAR and nursing is documenting. Nursing staff are being reminded in Memo form to document flushes in the Intake section of the Patient's Flow Record (nursing note). Clinical record 5 client PT/OT recommendation for in the home has been requested. PT/OT to re-evaluate client due to current hand splint not fitting properly. An order has been obtained for PT/OT to evaluate and size for hand splint. Once the splint is obtained a copy of PT/OT recommendations and will be placed it on the MAR/Treatment Record for nursing to follow and document. Clinical record 6,10 and 11 corrections is included in N522 step 1. 3) The DON will review schedules on a monthly basis to ensure services schedule are in compliance with the POC. Compliance Date 2/14/14 N537 1) The agency is reviewing all clients plan of care and Medicaid prior authorizations and waiver hours and writing addendums to the plan of care to ensure services are provided accordingly. Client's schedules have been revised to reflect clarifications in each client's plan</p>				

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	<p>10/30/13, 11/4/13, 11/6/13, 11/11/13, 11/13/12, 11/18/13, 11/20/13, 11/22/13, 11/25/13, 12/2/13, 12/4/13, 12/9/13, 12/11/13, 12/16/13, and 12/18/13.</p> <p>B. The clinical record evidenced 10 hours 10/22/13, 10/24/13, 10/25/13, 10/29/13, 10/31/13, 11/1/13, 11/5/13, 10/7/13, 10/8/13, 11/12/13, 11/14/13, 11/15/13, 11/19/13, 11/21/13, 11/22/13, 11/26/13, 11/29/13, 12/3/13, 12/5/13, 12/6/13, 12/10/13, 12/12/13, 12/13/13, 12/17/13, and 10 hours 12/19/13.</p> <p>C. The clinical record evidenced 0 hours on 11/27/13 and 11/28/13.</p> <p>D. On 1/24/14 at 1:15 PM, the DON, Employee A, indicated hours provided were not as ordered.</p> <p>3. Clinical record 4, SOC 7/1/12, evidenced physician orders for the certification period 10/25/13 through 12/23/13 for the SN to "check placement of G-tube. SN to check for residual if greater than 50 ml, ..."</p> <p>A. The clinical record failed to evidence checking G-tube placements, flushing of G-tube before and after feeding, and checking for residual on 10/24/13, 10/25/13, 10/26/13, 10/27/13, 10/28/13, 10/30/13, 10/31/13, 11/2/13,</p>		<p>of care addendum. Clinical record 1, regarding "Cough Assist" and "Chest Percussion Vest" are listed on the MAR/Treatment Record and documented. The straight cath order has been changed to 2-3 times daily PRN per clean technique if patients I & O vary, etc. Clinical record 3,10 and 11 clients corrections are same as N537 - 1 Clinical record 4, g-tube placement check and residual check are on the MAR/Treatment record. Nursing staff have been informed to follow physician's order regarding placement and residual and document findings on the MAR. G-tube flush is on the MAR and nursing is documenting. Nursing staff are being reminded in Memo form to document flushes in the Intake section of the Patient's Flow Record (nursing note). Clinical record 5 client PT/OT recommendation for in the home has been requested. PT/OT to re-evaluate client due to current hand splint not fitting properly. An order has been obtained for PT/OT to evaluate and size for hand splint. Once the splint is obtained a copy of PT/OT recommendations and will be placed it on the MAR/Treatment Record for nursing to follow and document.</p>				

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	<p>11/3/13, 11/4/13, 11/5/13, 11/6/13, 11/7/13, 11/8/13, 11/9/13, 11/10/13, 11/11/13, 11/12/13, 11/13/13, 11/14/13, 11/16/13, 11/17/13, 11/18/13, 11/20/13, 11/21/13, 11/22/13, 11/23/13, 11/24/13, 11/25/13, 11/26/13, 11/27/13, 11/28/13, 11/30/13, 12/1/13, 12/2/13, 12/3/13, 12/4/13, 12/5/13, 12/6/13, 12/7/13, 12/8/13, 12/9/13, 12/11/13, 12/12/13, 12/13/13, 12/14/13, 12/15/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/22/13, and 12/23/13.</p> <p>B. The clinical record failed to evidence checking G-tube placements and flushing of G-tube before and after feeding on 10/29/13, 11/11/13, 11/15/13, 11/19/13, 11/29/13, 12/10/13 and 12/13/13.</p> <p>C. On 1/24/14 at 1:25 PM, the DON, Employee A, indicated the services were not performed as ordered.</p> <p>4. Clinical record 5, SOC 5/8/13, evidenced physician orders for the certification period 10/24/13 through 12/22/13 for 37.5 hours per week with SN to follow PT (physical therapist) / OT (occupational therapist) recommendations per treatment plan present in the client's home. SN to apply hand splint to the client's left arm, on for two hours and off for two hours, for up</p>						

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	<p>to eight hours a day.</p> <p>A. The clinical record failed to evidence 37.5 hours week 1, week 2, week 3, week 4, week 5, week 7, week 8, and week 9.</p> <p>B. The clinical record failed to evidence a PT/OT therapist treatment plan was available for personnel to follow.</p> <p>C. The clinical record failed to evidence the SN applied the hand splint to the client's left arm on 10/25/13, 10/28/13, 10/29/13, 10/30/13, 10/31/13, 11/1/13, 11/2/13, 11/4/13, 11/5/13, 11/6/13, 11/7/13, 11/8/13, 11/11/13, 11/12/13, 11/13/13, 11/14/14, 11/15/13, 11/18/13, 11/19/13, 11/20/13, 11/21/13, 11/22/13, 11/25/13, 11/26/13, 11/26/13, 11/29/13, 12/2/13, 12/3/13/, 12/4/13, 12/5/13, 12/6/13, 12/7/13, 12/9/13, 12/10/13, 12/11/13, 12/12/13, 12/13/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/21/13, and 12/22/13.</p> <p>D. On 1/24/14 at 1:30 PM, the DON, Employee A, indicated the services were not performed as ordered.</p> <p>5. Clinical record 6, SOC 4/29/13, evidenced physician orders for the certification period 10/26/13 through</p>						

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	<p>12/24/13 for client to receive home health aide (HHA) services funded through Medicaid PA for visits of 40 hours per week.</p> <p>A. The clinical record failed to evidence 40 hours week 1, week 2, week 3, week 4, week 5, week 6, week 7, week 8, and week 9.</p> <p>B. On 1/24/14 at 1: 35 PM, the DON, Employee A, indicated the hours were not as ordered.</p> <p>6. Clinical record 10, SOC 11/26/12, evidenced physician orders for the certification period 11/23/13 through 1/21/14 for client to receive respite up to 5 hours a day 2 days a week.</p> <p>A. The clinical record evidenced three days week 4 and week 9.</p> <p>B. On 1/24/14 at 1:50 PM, the DON indicated the visits were incorrect.</p> <p>7. Clinical record 11, SOC 4/16/12, evidenced physician orders for the certification period 12/6/13 through 2/3/14 for client to receive services 9 hours a day 6 days a week.</p> <p>A. The clinical record fails to evidence 6 days during week 2 and week</p>						

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N000537	<p>4.</p> <p>B. On 1/24/14 at 2:00 PM the DON Employee A indicated the visits were incorrect.</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on clinical record review and interview the agency failed to ensure their personnel provided skilled nursing services according to physician orders in the patient's plan of care in 6 of 11 clinical records reviewed with the potential to affect all 19 patients. (1, 3, 4, 5, 10, and 11)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 8/8/12, evidenced physician orders for the certification period 11/24/13 through 1/22/14 for 9 hours of skilled nursing Monday through Friday for a total of skilled nursing hours of 45 per week. Patient receives 60 hours respite per month. The nurse is to perform "Cough Assist (CA): Skilled Nurse (SN) to administer cough assist as ordered. ... Chest Percussion Vest (CP): Vest is noted to be pre-programmed. SN to</p>	N000537	<p>1) The agency is reviewing all clients plan of care and Medicaid prior authorizations and waiver hours and writing addendums to the plan of care to ensure services are provided accordingly. Client's schedules have been revised to reflect clarifications in each client's plan of care addendum.</p> <p>Clinical record 1, regarding "Cough Assist" and "Chest Percussion Vest" are listed on the MAR/Treatment Record and documented. The straight cath order has been changed to 2-3 times daily PRN per clean technique if patients I & O vary, etc. Clinical record 3,10 and 11 clients corrections are same as N537 - 1 Clinical record 4, g-tube placement check and residual check are on the MAR/Treatment record. Nursing staff have been informed to follow physician's order regarding placement and residual and document findings on the MAR. G-tube flush is on the MAR and</p>	02/14/2014			

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	<p>utilize Program ... SN to utilize morning and night before client goes to bed. ... SN to perform straight catheterization of the client's bladder 2-3 times daily per clean technique."</p> <p>A. The clinical record failed to evidence CA and CP on 11/28/13, 12/6/13, 12/13/13, 12/19/13, and 12/25/13. The clinical record failed to evidence straight catheterization of the client's bladder 2-3 times daily per clean technique at any time.</p> <p>B. On 1/24/14 at 1 PM the Director of Nursing (DON), Employee A, indicated these services had not been performed as ordered.</p> <p>2. Clinical record 3, SOC 10/22/13, evidenced physician orders for the certification period 10/20/13 through 12/18/13 for SN services 5 days a week for 8 hours a day.</p> <p>A. The clinical record evidenced 12 hours 10/21/13, 10/23/13, 10/28/13, 10/30/13, 11/4/13, 11/6/13, 11/11/13, 11/13/12, 11/18/13, 11/20/13, 11/22/13, 11/25/13, 12/2/13, 12/4/13, 12/9/13, 12/11/13, 12/16/13, and 12/18/13.</p> <p>B. The clinical record evidenced 10 hours 10/22/13, 10/24/13, 10/25/13,</p>		<p>nursing is documenting. Nursing staff are being reminded in Memo form to document flushes in the Intake section of the Patient's Flow Record (nursing note). Clinical record 5 client PT/OT recommendation for in the home has been requested. PT/OT to re-evaluate client due to current hand splint not fitting properly. An order has been obtained for PT/OT to evaluate and size for hand splint. Once the splint is obtained a copy of PT/OT recommendations and will be placed it on the MAR/Treatment Record for nursing to follow and document.</p>				

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	<p>10/29/13, 10/31/13, 11/1/13, 11/5/13, 10/7/13, 10/8/13, 11/12/13, 11/14/13, 11/15/13, 11/19/13, 11/21/13, 11/22/13, 11/26/13, 11/29/13, 12/3/13, 12/5/13, 12/6/13, 12/10/13, 12/12/13, 12/13/13, 12/17/13, and 10 hours 12/19/13.</p> <p>C. The clinical record evidenced 0 hours on 11/27/13 and 11/28/13.</p> <p>D. On 1/24/14 at 1:15 PM, the DON, Employee A, indicated hours provided were not as ordered.</p> <p>3. Clinical record 4, SOC 7/1/12, evidenced physician orders for the certification period 10/25/13 through 12/23/13 for the SN to "check placement of G-tube. SN to check for residual if greater than 50 ml,"</p> <p>A. The clinical record failed to evidence checking G-tube placements, flushing of G-tube before and after feeding, and checking for residual on 10/24/13, 10/25/13, 10/26/13, 10/27/13, 10/28/13, 10/30/13, 10/31/13, 11/2/13, 11/3/13, 11/4/13, 11/5/13, 11/6/13, 11/7/13, 11/8/13, 11/9/13, 11/10/13, 11/11/13, 11/12/13, 11/13/13, 11/14/13, 11/16/13, 11/17/13, 11/18/13, 11/20/13, 11/21/13, 11/22/13, 11/23/13, 11/24/13, 11/25/13, 11/26/13, 11/27/13, 11/28/13, 11/30/13, 12/1/13, 12/2/13, 12/3/13,</p>						

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	<p>12/4/13, 12/5/13, 12/6/13, 12/7/13, 12/8/13, 12/9/13, 12/11/13, 12/12/13, 12/13/13, 12/14/13, 12/15/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/22/13, and 12/23/13.</p> <p>B. The clinical record failed to evidence checking G-tube placements and flushing of G-tube before and after feeding on 10/29/13, 11/11/13, 11/15/13, 11/19/13, 11/29/13, 12/10/13 and 12/13/13.</p> <p>C. On 1/24/14 at 1:25 PM, the DON, Employee A, indicated the services were not performed as ordered.</p> <p>4. Clinical record 5, SOC 5/8/13, evidenced physician orders for the certification period 10/24/13 through 12/22/13 for 37.5 hours per week with SN to follow PT (physical therapist) / OT (occupational therapist) recommendations per treatment plan present in the client's home. SN to apply hand splint to the client's left arm, on for two hours and off for two hours, for up to eight hours a day.</p> <p>A. The clinical record failed to evidence 37.5 hours week 1, week 2, week 3, week 4, week 5, week 7, week 8, and week 9.</p>						

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	<p>B. The clinical record failed to evidence a PT/OT therapist treatment plan was available for personnel to follow.</p> <p>C. The clinical record failed to evidence the SN applied the hand splint to the client's left arm on 10/25/13, 10/28/13, 10/29/13, 10/30/13, 10/31/13, 11/1/13, 11/2/13, 11/4/13, 11/5/13, 11/6/13, 11/7/13, 11/8/13, 11/11/13, 11/12/13, 11/13/13, 11/14/14, 11/15/13, 11/18/13, 11/19/13, 11/20/13, 11/21/13, 11/22/13, 11/25/13, 11/26/13, 11/26/13, 11/29/13, 12/2/13, 12/3/13/, 12/4/13, 12/5/13, 12/6/13, 12/7/13, 12/9/13, 12/10/13, 12/11/13, 12/12/13, 12/13/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/21/13, and 12/22/13.</p> <p>D. On 1/24/14 at 1:30 PM, the DON, Employee A, indicated the services were not performed as ordered.</p> <p>5. Clinical record 10, SOC 11/26/12, evidenced physician orders for the certification period 11/23/13 through 1/21/14 for client to receive respite up to 5 hours a day 2 days a week.</p> <p>A. The clinical record evidenced three days week 4 and week 9.</p> <p>B. On 1/24/14 at 1:50 PM, the DON</p>						

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N000557	<p>indicated the visits were incorrect.</p> <p>6. Clinical record 11, SOC 4/16/12, evidenced physician orders for the certification period 12/6/13 through 2/3/14 for client to receive SN services 9 hours a day 6 days a week.</p> <p>A. The clinical record fails to evidence 6 days during week 2 and week 4.</p> <p>B. On 1/24/14 at 2:00 PM the DON Employee A indicated the visits were incorrect.</p> <p>410 IAC 17-14-1(a)(2)(E) Scope of Services Rule 14 Sec. 1(a) (2)(E) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (E) Assist the patient in learning appropriate self-care techniques. Based on observation and interview the agency failed to ensure the licensed practical nurse assisted the patient in learning redirection techniques in 1 of 3 home visits with the potential to affect all 19 patients. (2)</p>	N000557	1) The noted citations have been or will be corrected in the following manner to ensure our staff follow acceptable professional standards.1) Employee D was re-educated on the proper utilization of using a three point restraint and on reporting malfunctions or needed repairs	02/14/2014			

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	<p>Findings:</p> <p>1. On 1/22/14 at 9:50 AM a home visit was made to Patient # 5 with the Director of Nursing (DON) and Assistant Director of Nursing (ADON). The patient is a non ambulatory, non verbal child with no intentional muscle movement. Patient was observed on the floor. The LPN (licensed practical nurse), Employee D, picked the patient up and placed the patient in a wheelchair. The LPN secured the safety device between the thighs and attached one side of the three point chest restraint. The left side clip was broken and would not attach. The patient likes to chew on the broken clip because of the hardness. There is a soft chew toy attached to the chair but the patient will not redirect to the soft toy. The ADON found a hard chew toy for the patient and instructed the LPN to put the tray on the chair. With the tray on, the patient still prefers the clip but with persistence was redirected to the hard chew toy. The LPN went to a chair across the room and sat down and let the ADON redirect the patient. The patient has a 16 Fr. 1.5 CM J/G Mic-Key Button gastronomy tube for feedings. There was formula from the previous feeding in the tubing and bag. The LPN connected the tubing without cleaning</p>		<p>on equipment. The broken clip to the restraint has been replaced. Employee D was re-educated on acceptable techniques to use when trying to redirect a client. Employee D was reminded of professional standards when in a client's home. Employee D was re-educated on acceptable infection control practices regarding cleaning and re-use of feeding bags; cleaning of the male and female parts of tubing before connecting, and re-education on when to wash hands and when and to wear gloves. Since all clients have the potential to be affected by this citing, a memo will be sent out to all staff reminding them to follow acceptable professional standards while in a client's home. 2) To ensure this citing does not recur, the ADON and Clinical Supervisor will visit the client every 2 weeks times 1 month to observe for compliance and then monthly thereafter with observations being documented and all other nursing staff will be monitored for compliance during monthly visits. 3) The DON will review documentation of visits to ensure Employee D is following client as needed and acceptable Professional standards being followed.</p>				

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	<p>either end, cleaning her hands, or wearing gloves. She then opened a new container of formula and poured it into the bag with the old formula. The LPN then returned to the chair across the room and put her feet up. The patient started to chew on the clip again and the ADON got up and redirected with the hard chew toy.</p> <p>2. On 1/22/14 at 11 AM, the DON, Employee A, indicated she would have expected to see the LPN cleanse her hands, cleanse the tubing, and wear gloves. She did not know the clip was broken, and, even if dad did fix these things, they needed to take care of the broken clip so the patient wouldn't chew on it and there would be no chance the patient would slip from the chair. She would have expected the LPN to be the one up and redirecting the child with a different hard chew toy and to find a solution to the clip.</p>				