

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2012
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NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7131 AIGNER CT INDIANAPOLIS, IN 46278
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
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G0000	<p>This visit was for a home health initial medicaid certification survey. This was a partial extended survey.</p> <p>Survey dates: 1/17-20/12</p> <p>Facility # 012680</p> <p>Survey Team:</p> <p>Dawn Snider, RN, PHNS</p> <p>Census Service Type:</p> <p>Skilled Patients: 18 Home Health Aide Only Patients: 0 Personal Service Only Patients: 1 Total: 19</p> <p>Sample:</p> <p>RR w HV: 5 RR w/o HV: 5</p> <p>Total RR: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 2, 2012</p>	G0000		
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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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G0144	<p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses coordinated the patient's care for 5 of 10 patient records reviewed (2, 3, 4, 5, and 7) with the potential to affect all the patients of the agency who received care from more than one service.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2, start of care 11/23/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 2. Clinical record #3, start of care 11/21/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the occupational therapist. 3. Clinical record #4, start of care 11/4/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 4. Clinical record #5, start of care 12/9/11, failed to evidence any 			G0144	<p>Pure Home Health is conducting cordination of Care within the first 5 days of patients SOC. We use the EMR system to notify each discipline of the patients they need to see. Within the EMR system, once the SOC has been completed, the Care Plans and 485 are available for each discipline to review. This will be documented on a Progress note or Case Conference Summary. the Staffing Coordinator or Designee will be responsible for ensuring complaince. This will be reiwed weekly on the EMR system. This will be completed on 2/13/12. In regards to Tag G0144.</p>		01/27/2012

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	<p>documentation the registered nurse coordinated the patient's care with the home health aide, physical therapist, and occupational therapist.</p> <p>5. Clinical record #7, start of care 10/24/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the therapist.</p> <p>6. The undated policy titled "C-360 Coordination of Client Services" states, "1. Care conferences will be held as necessary to establish interchange, reporting and coordinated evaluation between all disciplines involved in the client's care. 4. Ongoing care conferences shall be conducted to evaluate the client's status and progress ... 6. Care conferences will be documented on the Care Conference Summary form or in the progress notes."</p> <p>7. On 1/20/11 at 10:00 AM, the director of nursing indicated case conferences were conducted between disciplines but were not documented.</p>						

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G0145	<p>A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure a summary report had been sent to the physician at least every 60 days for 1 of 3 (1) records reviewed that had received services more than 60 days with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care 11/2/11, failed to evidence the registered nurse completed and sent a 60 day summary report to the physician. 2. On 1/20/2012 at 10:00 AM, the director of nursing indicated patient #1 had not had a 60 day summary sent to the physician. 3. The undated policy titled " C-645 Medical Supervision" states, "5. Written reports on the client's condition are provided to the physician at least every sixty days. 4. The undated policy titled " C-650 Physician Summary" states, "A summary 	G0145	<p>Pure Home Health does conduct routine Care Confrences. We have corrected difficiency by using the document in EMR system under 60day/Care Conference form as needed and routinely on Recertification or Discharge. This is then delivered to the Physician for signature. The person responsible will be the Director of Nursing, or Disignee to monitor Case Confrences. To prevent this difficiency from reoccurring, we will ensure complaince through weekly review of patients on case load and will be completed by 1/27/2012 and ongoing. Regarding Tag G0145</p>	01/27/2012			

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	report will be provided to the physician no less than every sixty (60) days."			

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G0158	<p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and policy review and interview, the agency failed to visits and treatments were provided as ordered for 4 of 9 records with a written plan of care (3, 4, 5, and 6) and the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 3, start of care 11/21/11, included a plan of care for the certification period 11/21/11-1/19/12 with orders for skilled nurse visits 2 times a week for 9 weeks. The record failed to evidence skilled nurse visits the week of 11/25/11. 2. Clinical record #4, start of care 11/4/11, included a plan of care for the certification period 11/4/11-1/2/12 with orders for home health aide 3 times a week for 8 weeks. Home health aide visits were made 5 times a week from 11/20/11 until 1/2/12. <p>On 1/20/12 at 4:20 PM, the administrator and the director of nursing indicated there were no orders for 5 times a week for certification period</p>	G0158	<p>Pure Home Health has reinforced in writing with each staff memeber of following frequency according to our weeks. Pure Home Health Care has established Saturday through Friday is our week. Therefore any change in frequency the Case Manager or Disignee will obtain Physician orders. The Director of Nursing or Disignee will monitor each patient on a weekly basis to monitor frequencies, and disciplinary actions will be taken for those individuals not following thier frequencies. The deficiency was corrected on: 2/13/12 Regarding Tag G0158</p>	02/13/2012			

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	<p>11/4/11-1/2/12.</p> <p>3. Clinical record # 5, start of care 12/9/11, included a plan of care for the certification period 12/9/11 - 2/6/12 with orders for skilled nurse visits 1 time a week for 3 weeks. The record failed to evidence the skilled nurse made visits on the week of 12/11/11 and made visits on both 12/21 and 12/22/11.</p> <p>4. Clinical record #6, start of care 11/18/11, included a plan of care for the certification period 11/18/2011-1/16/12 with orders for skilled nursing 1 time a week for 1 week then 3 times a week for 3 weeks. The record evidenced only 2 skilled nurse visits the week of 11/20/11, on 11/21 and 11/23/11.</p> <p>A. The clinical record included labs results dated 11/30, 12/3, and 12/8/11. The plan of care failed to evidence an order for the labs.</p> <p>1.) On 1/20/12 at 12:20 PM, employee M, the registered nurse, indicated she was monitoring the patient's PT/INR's with a coaguchek machine.</p> <p>2.) On 1/20/12 at 12:40 PM, the administrator and the director of nursing indicated the plan of care did not contain orders for labs to be drawn on 11/30,</p>						

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	<p>12/3, and 12/8/11.</p> <p>B. The plan of care included orders for a neurological assessment at each visit. The record failed to evidence a neurological assessment was completed on 11/21, 23, 28, and 30; 12/3, 8, 12, 16, and 12/23/11; and 1/6, 9 and 12/12.</p> <p>On 1/18/12 at 9:45 AM during the home visit, the director of nursing, who was making the skilled nurse, visit failed to do a neurological assessment.</p> <p>5. The undated agency policy titled "B-360 Laboratory Testing" states, "Policy ... Testing done will be according to physician orders."</p> <p>7. The undated agency policy titled "C-580 Plan of Care" states, "1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: ... l. Medications, treatments, and procedures. m. Medical supplies and equipment required."</p>						

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G0159	<p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, observation, interview, and policy review, the agency failed to ensure the plan of care was signed by the physician timely and included all the required elements in 7 of 9 (1, 2, 3, 4, 5, 6, and 8) clinical records reviewed with a plan of care and the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1 evidenced the physician signed the plan of care for the certification period of 11/2/11-12/31/11 on 1/17/12, over 30 days from the beginning of the certification period. 2. Clinical record #2 included a plan of care for the certification period of 11/23/11-1/21/12 that failed to include nutritional requirements, allergies, orders, and medications. 	G0159	<p>Pure Home Health will correct the difficiency by tracking through the EMR system and reviewing the managed orders/date tracker. We have implimented policy/procedure: After 72 hours of POC/subsequent orders not being returned, Staffing Coordinator or Disignee will call physicians office to obtain order. At day 15 if signed order has not been recieved, the Business Development Representative will hand deliver orders to obtain signature. The deficiency was corrected: 1/27/2012 TAG G0159</p>	01/27/2012			

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	<p>3. Clinical record #3 included a plan of care for the certification period of 11/21/11-1/19/12 that had not been signed by the physician.</p> <p>4. Clinical record #4 included a plan of care for the certification period of 11/4/11-1/2/12 which the physician signed on 1/9/12, over 30 days from the beginning of the certification period.</p> <p>5. Clinical record #5 included a plan of care for the certification period of 12/9/11-2/6/12 which the physician signed on 1/11/12, over 30 days from the beginning of the certification period.</p> <p>6. Clinical record # 6 included a plan of care for the certification period 11/18/11 - 1/16/12 that failed to evidence the patient had a wheelchair, walker, and glucometer; dressing supplies; and nitroglycerin medication.</p> <p>On 1/18/12 at 9:45 AM, during the home visit, the patient was observed sitting in a wheelchair with a walker visible. The patient also indicated there were dressing supplies and nitroglycerin was taken for chest pain.</p> <p>On 1/18/12 at 5:30 PM, the director of nursing indicated the patient had a glucometer to for self blood glucose</p>			
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	<p>monitoring.</p> <p>7. Clinical record #8 included a plan of care for the certification period of 11/3/11-1/1/12 which was signed by the physician on 12/20/11, over 30 days from the beginning of the certification period.</p> <p>8. The undated policy titled "Physician Signature Return Policy and Procedure" states, "If at day 25 the order has yet to be received with a signature, a member of Pure Home Health Care will hand deliver the order to physician's office to have the signature obtained."</p> <p>9. The undated policy titled "C-635 All medications, treatments and services provided to clients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner.</p> <p>10. The undated agency policy titled, "C-580 Plan of Care" states, "1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: ... l. Medications, treatments, and procedures. m. Medical supplies and equipment required. ... 9. Professional staff shall</p>						

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	promptly alert the physician to any changes that suggest a need to alter the Plan of Care."			
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G0170	<p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure skilled nursing services were provided in accordance with the plan of care on 3 of 8 (3, 5, and 6) records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients who received skilled nursing services.</p> <p>Findings:</p> <p>1. Clinical record # 3, start of care 11/21/11, included a plan of care for the certification period 11/21/11-1/19/12 with orders for skilled nurse visits 2 times a week for 9 weeks. The record failed to evidence skilled nurse visits the week of 11/25/11.</p> <p>2. Clinical record # 5, start of care 12/9/11, included a plan of care for the certification period 12/9/11 - 2/6/12 with orders for skilled nurse visits 1 time a week for 3 weeks. The record failed to evidence the skilled nurse made visits on the week of 12/11/11 and made visits on both 12/21 and 12/22/11.</p> <p>3. Clinical record #6, start of care 11/18/11, included a plan of care for the certification period 11/18/2011-1/16/12 with orders for skilled nursing 1 time a</p>	G0170	<p>Pure Home Health has reinforced in writing with each staff memeber of following frequency according to our weeks. Pure Home Health Care has established Saturday through Friday is our week. Therefore any change in frequency the Case Manager or Disignee will obtain Physician orders. The Director of Nursing or Disignee will monitor each patient on a weekly basis to monitor frequencies, and disciplinary actions will be taken for those individuals not following thier frequencies. The deficiency was corrected on: 2/13/12 Regarding G0170</p>	02/13/2012			

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	<p>week for 1 week then 3 times a week for 3 weeks. The record evidenced only 2 skilled nurse visits the week of 11/20/11, on 11/21 and 11/23/11.</p> <p>A. The clinical record included labs results dated 11/30, 12/3, and 12/8/11. The plan of care failed to evidence an order for the labs.</p> <p>1.) On 1/20/12 at 12:20 PM, employee M, the registered nurse, indicated she was monitoring the patient's PT/INR's with a coaguchek machine.</p> <p>2.) On 1/20/12 at 12:40 PM, the administrator and the director of nursing indicated the plan of care did not contain orders for labs to be drawn on 11/30, 12/3, and 12/8/11.</p> <p>B. The plan of care included orders for a neurological assessment at each visit. The record failed to evidence a neurological assessment was completed on 11/21, 23, 28, and 30; 12/3, 8, 12, 16, and 12/23/11; and 1/6, 9 and 12/12.</p> <p>On 1/18/12 at 9:45 AM during the home visit, the director of nursing, who was making the skilled nurse, visit failed to do a neurological assessment.</p>			
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G0173	<p>The registered nurse initiates the plan of care and necessary revisions.</p> <p>Based on clinical record and policy review, the agency failed to ensure the registered nurse specified the information on the plan of care in 3 of 9 clinical records reviewed with a plan of care (1, 2, and 6) with the potential to affect all of the agency's patients.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 11/2/11, included a plan of care for the certification period 1/1/12-2/29/12 that failed to evidence when to notify the physician for pain level. The plan of care states, "SN to report to physician if patient experiences pain level not acceptable to patient, pain level greater than __ (this was left blank), pain medications not effective, ..."</p> <p>2. Clinical record #2, start of care 11/23/11, included a plan of care for the certification period 11/23/11 -1/21/12, failed to evidence what the skilled nurse and the home health aide were supposed to do.</p> <p>3. Clinical record #6, start of care 11/18/11, included a plan of care for the certification period of 11/18/11-1/16/12</p>			G0173	<p>Pure Home Health will review all POC on Quality Assurance within the EMR System within 72 hours of receiving the POC to monitor completion of POC, i.e. all areas filled in correctly, all orders for each discipline will be complete on POC. Disciplinary actions will be taken on each Case Manager for incomplete documentation. The Director of Nursing or Disignee will be the one to ensure compliance and will conduct disciplinary actions as needed. The deficiency was corrected in 01/27/12 and ongoing. Regarding G0173</p>		01/27/2012

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	<p>that failed to evidence specific orders for the wound care and amount of insulin to be provided. The plan of care states, "SN [skilled nurse] to clean wound, ulcer with Normal Saline, pat dry, apply____ (this was left blank), pack with sterile ..."</p> <p>The plan of care further states, "SN to prep/administer, _____ (these were left blank), units QAM SQ and _____ (these were left blank), units QPM [ever night]. ... Sn [skilled nurse] to prep [prepare] /admin [administer] _____ (this was left blank) per sliding scale.</p> <p>4. The undated agency policy titled, "C-200 Skilled Nursing Services" states, "1. The registered nurse: ... c. Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan."</p>			
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G0176	<p>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. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses coordinated the patient's care for 5 of 10 patient records reviewed (2, 3, 4, 5, and 7) with the potential to affect all the patients of the agency who received care from more than one service.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2, start of care 11/23/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 2. Clinical record #3, start of care 11/21/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the occupational therapist. 3. Clinical record #4, start of care 11/4/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 4. Clinical record #5, start of care 12/9/11, failed to evidence any 	G0176	<p>Pure Home Health is conducting cordination of Care within the first 5 days of patients SOC. We use the EMR system to notify each discipline of the patients they need to see. Within the EMR system, once the SOC has been completed, the Care Plans and 485 are available for each discilpne to review. This will be documented on a Progress note or Case Conference Summary. the Staffing Coordinator or Designee will be responsible for ensuring complaince. This will be reiwed weekly on the EMR system. This will be completed on 2/13/12. Regarding G0176</p>	02/13/2012			

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	<p>documentation the registered nurse coordinated the patient's care with the home health aide, physical therapist, and occupational therapist.</p> <p>5. Clinical record #7, start of care 10/24/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the therapist.</p> <p>6. The undated policy titled "C-360 Coordination of Client Services" states, "1. Care conferences will be held as necessary to establish interchange, reporting and coordinated evaluation between all disciplines involved in the client's care. 4. Ongoing care conferences shall be conducted to evaluate the client's status and progress ... 6. Care conferences will be documented on the Care Conference Summary form or in the progress notes."</p> <p>7. On 1/20/11 at 10:00 AM, the director of nursing indicated case conferences were conducted between disciplines but were not documented.</p>						

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N0462	<p>Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review and interview, the agency failed to ensure all employees had a physical exam that identified the employee was free from communicable disease for 2 of 10 files reviewed (A and G) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file A, date of hire 10/11/11 and first patient contact 11/11/11, failed to evidence a physical exam that identified the employee was free of communicable disease. 2. Personnel file G, date of hire 11/16/11 and first patient contact 12/6/11, failed to evidence a physical exam that identified the employee was free of communicable disease. 3. On 1/20/2012 at 11:30 PM, the human resources director indicated there were no more documents available for the 	N0462	<p>Pure Home Health has developed Company Physical, that has a specified area for physicans to mark if the employee is free from communicable disease. The HR Director or Disignee will review each Physical Exam prior to any employee seeing a patient. This will be monitored on a ongoing basis upon hire of each employee. The deficiency will be corrected on 1/27/12.Pure Home Health will review current employee files, and will suspend all employees who do not have a physical stating free from communicable disease, until they recieve a physicans statement stating they are free of communicable disease or have our Company Physical filled out. Completed by 02/15/2012 Tag N0462</p>	02/15/2012			

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N0464	<p>Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with:</p> <p>(A) a documented:</p> <p>(i) history of tuberculosis;</p> <p>(ii) previously positive test result for tuberculosis; or</p> <p>(iii) completion of treatment for tuberculosis;</p> <p>or</p> <p>(B) newly positive results to the tuberculin skin test;</p> <p>must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must:</p> <p>(A) be completed annually; and</p> <p>(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p> <p>(A) work in the home health agency; or</p> <p>(B) provide direct patient contact;</p>			
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	<p>unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file review and interview, the agency failed to ensure all employees had been tested for tuberculosis for 3 of 10 files reviewed (A, G, and H) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Personnel file A, date of hire 10/11/11 and first patient contact 11/11/11, failed to evidence a 2 step TB test had been completed upon hire or that the employee had a PPD within the last 12 months. Personnel file G, date of hire 11/16/11 and first patient contact 12/6/11, failed to evidence a 2 step TB test had been completed upon hire or that the employee had a PPD within the last 12 months. Personnel file H, date of hire 11/8/11 and first patient contact 11/18/11, failed to evidence a 2 step TB test had been completed upon hire or that the employee had a PPD within the last 12 months. 	N0464	<p>Pure Home Health has created a policy/procedure stating that every new hire will need to provide the past 2 years of TB/ chest x-rays/quantiferon-tb assay. If the employee is unable to provide such documentation, Pure Home Health will conduct 1st and 2nd step TB. The HR Director or Disgnee will monitor this per hire and ongoing. For current employees are suspending all employees who do not have proof of the past 2 years, or have not recieved a 2nd step. Once they have proof of the prior 2 years or that they have recieved the 2nd step, we will then continue employment. HR Director or Designee will ensure compliance by 02/15/2012 TAG N0464</p>	02/15/2012			

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	4. On 1/20/2012 at 11:30 PM, the human resources director indicated there were no more documents available for the personnel records.			
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N0484	<p>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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses coordinated the patient's care for 5 of 10 patient records reviewed (2, 3, 4, 5, and 7) with the potential to affect all the patients of the agency who received care from more than one service.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2, start of care 11/23/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 2. Clinical record #3, start of care 11/21/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the occupational therapist. 3. Clinical record #4, start of care 11/4/11, failed to evidence any documentation the registered nurse 	N0484	Pure Home Health is conducting cordination of Care within the first 5 days of patients SOC. We use the EMR system to notify each discipline of the patients they need to see. Within the EMR system, once the SOC has been completed, the Care Plans and 485 are available for each discipne to review. This will be documented on a Progress note or Case Conference Summary. the Staffing Coordinator or Designee will be responsible for ensuring complaince. This will be reiwed weekly on the EMR system. This will be completed on 2/13/12.TAG N0484	02/13/2012			

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	<p>coordinated the patient's care with the home health aide.</p> <p>4. Clinical record #5, start of care 12/9/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide, physical therapist, and occupational therapist.</p> <p>5. Clinical record #7, start of care 10/24/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the therapist.</p> <p>6. The undated policy titled "C-360 Coordination of Client Services" states, "1. Care conferences will be held as necessary to establish interchange, reporting and coordinated evaluation between all disciplines involved in the client's care. 4. Ongoing care conferences shall be conducted to evaluate the client's status and progress ... 6. Care conferences will be documented on the Care Conference Summary form or in the progress notes."</p> <p>7. On 1/20/11 at 10:00 AM, the director of nursing indicated case conferences were conducted between disciplines but were not documented.</p>						

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N0522	<p>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:</p> <p>Based on clinical record and policy review and interview, the agency failed to visits and treatments were provided as ordered for 4 of 9 records with a written plan of care (3, 4, 5, and 6) and the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. Clinical record # 3, start of care 11/21/11, included a plan of care for the certification period 11/21/11-1/19/12 with orders for skilled nurse visits 2 times a week for 9 weeks. The record failed to evidence skilled nurse visits the week of 11/25/11.</p> <p>2. Clinical record #4, start of care 11/4/11, included a plan of care for the certification period 11/4/11-1/2/12 with orders for home health aide 3 times a week for 8 weeks. Home health aide visits were made 5 times a week from 11/20/11 until 1/2/12.</p> <p>On 1/20/12 at 4:20 PM, the administrator and the director of nursing</p>	N0522	Pure Home Health has reinforced in writing with each staff memeber of following frequency according to our weeks. Pure Home Health Care has established Saturday through Friday is our week. Therefore any change in frequency the Case Manager or Disignee will obtain Physician orders. The Director of Nursing or Disignee will monitor each patient on a weekly basis to monitor frequencies, and disciplinary actions will be taken for those individuals not following thier frequencies. The deficiency was corrected on: 2/13/12TAG N0522	02/13/2012			

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	<p>indicated there were no orders for 5 times a week for certification period 11/4/11-1/2/12.</p> <p>3. Clinical record # 5, start of care 12/9/11, included a plan of care for the certification period 12/9/11 - 2/6/12 with orders for skilled nurse visits 1 time a week for 3 weeks. The record failed to evidence the skilled nurse made visits on the week of 12/11/11 and made visits on both 12/21 and 12/22/11.</p> <p>4. Clinical record #6, start of care 11/18/11, included a plan of care for the certification period 11/18/2011-1/16/12 with orders for skilled nursing 1 time a week for 1 week then 3 times a week for 3 weeks. The record evidenced only 2 skilled nurse visits the week of 11/20/11, on 11/21 and 11/23/11.</p> <p>A. The clinical record included labs results dated 11/30, 12/3, and 12/8/11. The plan of care failed to evidence an order for the labs.</p> <p>1.) On 1/20/12 at 12:20 PM, employee M, the registered nurse, indicated she was monitoring the patient's PT/INR's with a coaguchek machine.</p> <p>2.) On 1/20/12 at 12:40 PM, the administrator and the director of nursing</p>						

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	<p>indicated the plan of care did not contain orders for labs to be drawn on 11/30, 12/3, and 12/8/11.</p> <p>B. The plan of care included orders for a neurological assessment at each visit. The record failed to evidence a neurological assessment was completed on 11/21, 23, 28, and 30; 12/3, 8, 12, 16, and 12/23/11; and 1/6, 9 and 12/12.</p> <p>On 1/18/12 at 9:45 AM during the home visit, the director of nursing, who was making the skilled nurse, visit failed to do a neurological assessment.</p> <p>5. The undated agency policy titled "B-360 Laboratory Testing" states, "Policy ... Testing done will be according to physician orders."</p> <p>7. The undated agency policy titled "C-580 Plan of Care" states, "1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: ... l. Medications, treatments, and procedures. m. Medical supplies and equipment required."</p>						

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N0524	<p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record review, observation, interview, and policy review, the agency failed to ensure the plan of care was signed by the physician timely and included all the required elements in 7 of 9 (1, 2, 3, 4, 5, 6, and 8) clinical records reviewed with a plan of care and the potential to affect all the patients of the agency.</p> <p>Findings include;</p> <p>1. Clinical record #1 evidenced the</p>	N0524	Pure Home Health will correct the difficiency by tracking through the EMR system and reviewing the managed orders/date tracker. We have implimented policy/procedure: After 72 hours of POC/subsequent orders not being returned, Staffing Coordinator or Disignee will call physicians office to obtain order. At day 15 if signed order has not been recieved, the Business Development Representative will hand deliver orders to obtain signature. The deficiency was corrected: 1/27/2012TAG N0524	01/27/2012			

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	<p>physician signed the plan of care for the certification period of 11/2/11-12/31/11 on 1/17/12, over 30 days from the beginning of the certification period.</p> <p>2. Clinical record #2 included a plan of care for the certification period of 11/23/11-1/21/12 that failed to include nutritional requirements, allergies, orders, and medications.</p> <p>3. Clinical record #3 included a plan of care for the certification period of 11/21/11-1/19/12 that had not been signed by the physician.</p> <p>4. Clinical record #4 included a plan of care for the certification period of 11/4/11-1/2/12 which the physician signed on 1/9/12, over 30 days from the beginning of the certification period.</p> <p>5. Clinical record #5 included a plan of care for the certification period of 12/9/11-2/6/12 which the physician signed on 1/11/12, over 30 days from the beginning of the certification period.</p> <p>6. Clinical record # 6 included a plan of care for the certification period 11/18/11 - 1/16/12 that failed to evidence the patient had a wheelchair, walker, and glucometer; dressing supplies; and nitroglycerin medication.</p>			

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	<p>On 1/18/12 at 9:45 AM, during the home visit, the patient was observed sitting in a wheelchair with a walker visible. The patient also indicated there were dressing supplies and nitroglycerin was taken for chest pain.</p> <p>On 1/18/12 at 5:30 PM, the director of nursing indicated the patient had a glucometer to for self blood glucose monitoring.</p> <p>7. Clinical record #8 included a plan of care for the certification period of 11/3/11-1/1/12 which was signed by the physician on 12/20/11, over 30 days from the beginning of the certification period.</p> <p>8. The undated policy titled "Physician Signature Return Policy and Procedure" states, "If at day 25 the order has yet to be received with a signature, a member of Pure Home Health Care will hand deliver the order to physician's office to have the signature obtained."</p> <p>9. The undated policy titled "C-635 All medications, treatments and services provided to clients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner.</p>						

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	<p>10. The undated agency policy titled, "C-580 Plan of Care" states, "1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: ... l. Medications, treatments, and procedures. m. Medical supplies and equipment required. ... 9. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."</p>			
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N0529	<p>Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the:</p> <p>(A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure a summary report had been sent to the physician at least every 60 days for 1 of 3 (1) records reviewed that had received services more than 60 days with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 11/2/11, failed to evidence the registered nurse completed and sent a 60 day summary report to the physician.</p> <p>2. On 1/20/2012 at 10:00 AM, the director of nursing indicated patient #1 had not had a 60 day summary sent to the physician.</p> <p>3. The undated policy titled " C-645 Medical Supervision" states, "5. Written reports on the client's condition are provided to the physician at least every sixty days.</p>	N0529	<p>Pure Home Health does conduct routine Care Confrences. We have corrected difficiency by using the document in EMR system under 60day/Care Conference form as needed and routinely on Recertification or Discharge. This is then delivered to the Physician for signature. The person responsible will be the Director of Nursing, or Disignee to monitor Case Confrences. To prevent this difficiency from reoccurring, we will ensure complaince through weekly review of patients on case load and will be completed by 1/27/2012 and ongoing.TAG N0529</p>	01/27/2012			

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	4. The undated policy titled " C-650 Physician Summary" states, "A summary report will be provided to the physician no less than every sixty (60) days."			
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N0537	<p>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 skilled nursing services were provided in accordance with the plan of care on 3 of 8 (3, 5, and 6) records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients who received skilled nursing services.</p> <p>Findings:</p> <p>1. Clinical record # 3, start of care 11/21/11, included a plan of care for the certification period 11/21/11-1/19/12 with orders for skilled nurse visits 2 times a week for 9 weeks. The record failed to evidence skilled nurse visits the week of 11/25/11.</p> <p>2. Clinical record # 5, start of care 12/9/11, included a plan of care for the certification period 12/9/11 - 2/6/12 with orders for skilled nurse visits 1 time a week for 3 weeks. The record failed to evidence the skilled nurse made visits on the week of 12/11/11 and made visits on both 12/21 and 12/22/11.</p> <p>3. Clinical record #6, start of care</p>	N0537	Pure Home Health has reinforced in writing with each staff memeber of following frequency according to our weeks. Pure Home Health Care has established Saturday through Friday is our week. Therefore any change in frequency the Case Manager or Disignee will obtain Physician orders. The Director of Nursing or Disignee will monitor each patient on a weekly basis to monitor frequencies, and disciplinary actions will be taken for those individuals not following thier frequencies. The deficiency was corrected on: 2/13/12TAG N0537	02/13/2012			

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	<p>11/18/11, included a plan of care for the certification period 11/18/2011-1/16/12 with orders for skilled nursing 1 time a week for 1 week then 3 times a week for 3 weeks. The record evidenced only 2 skilled nurse visits the week of 11/20/11, on 11/21 and 11/23/11.</p> <p>A. The clinical record included labs results dated 11/30, 12/3, and 12/8/11. The plan of care failed to evidence an order for the labs.</p> <p>1.) On 1/20/12 at 12:20 PM, employee M, the registered nurse, indicated she was monitoring the patient's PT/INR's with a coaguchek machine.</p> <p>2.) On 1/20/12 at 12:40 PM, the administrator and the director of nursing indicated the plan of care did not contain orders for labs to be drawn on 11/30, 12/3, and 12/8/11.</p> <p>B. The plan of care included orders for a neurological assessment at each visit. The record failed to evidence a neurological assessment was completed on 11/21, 23, 28, and 30; 12/3, 8, 12, 16, and 12/23/11; and 1/6, 9 and 12/12.</p> <p>On 1/18/12 at 9:45 AM during the home visit, the director of nursing, who was making the skilled nurse, visit failed</p>						

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	to do a neurological assessment.			
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N0542	<p>Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record and policy review, the agency failed to ensure the registered nurse specified the information on the plan of care in 3 of 9 clinical records reviewed with a plan of care (1, 2, and 6) with the potential to affect all of the agency's patients.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 11/2/11, included a plan of care for the certification period 1/1/12-2/29/12 that failed to evidence when to notify the physician for pain level. The plan of care states, "SN to report to physician if patient experiences pain level not acceptable to patient, pain level greater than __ (this was left blank), pain medications not effective, ..."</p> <p>2. Clinical record #2, start of care 11/23/11, included a plan of care for the certification period 11/23/11 -1/21/12, failed to evidence what the skilled nurse and the home health aide were supposed to do.</p>	N0542	<p>Pure Home Health will review all POC on Quality Assurance within the EMR System within 72 hours of recieveing the POC to monitor completion of POC, i.e. all areas filled in correctly, all orders for each discipline will be complete on POC. Disciplinary actions will be taken on each Case Manager for incomplete documentation. The Director of Nursing or Disignee will be the one to ensure complaince and will conduct disciplinary actions as needed. The deficiency was corrected in 01/27/12 and ongoingTAG N0542</p>	01/27/2012			

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	<p>3. Clinical record #6, start of care 11/18/11, included a plan of care for the certification period of 11/18/11-1/16/12 that failed to evidence specific orders for the wound care and amount of insulin to be provided. The plan of care states, "SN [skilled nurse] to clean wound, ulcer with Normal Saline, pat dry, apply_____ (this was left blank), pack with sterile ..."</p> <p>The plan of care further states, "SN to prep/administer, _____ (these were left blank), units QAM SQ and _____ (these were left blank), units QPM [ever night]. ... Sn [skilled nurse] to prep [prepare] /admin [administer] _____ (this was left blank) per sliding scale.</p> <p>4. The undated agency policy titled, "C-200 Skilled Nursing Services" states, "1. The registered nurse: ... c. Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan."</p>			
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N0545	<p>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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses coordinated the patient's care for 5 of 10 patient records reviewed (2, 3, 4, 5, and 7) with the potential to affect all the patients of the agency who received care from more than one service.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2, start of care 11/23/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 2. Clinical record #3, start of care 11/21/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the occupational therapist. 3. Clinical record #4, start of care 11/4/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the 	N0545	<p>Pure Home Health is conducting cordination of Care within the first 5 days of patients SOC. We use the EMR system to notify each discipline of the patients they need to see. Within the EMR system, once the SOC has been completed, the Care Plans and 485 are available for each discipne to review. This will be documented on a Progress note or Case Conference Summary. the Staffing Coordinator or Designee will be responsible for ensuring complaince. This will be reiwed weekly on the EMR system. This will be completed on 2/13/12.TAG N0545</p>	02/13/2012
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	<p>home health aide.</p> <p>4. Clinical record #5, start of care 12/9/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide, physical therapist, and occupational therapist.</p> <p>5. Clinical record #7, start of care 10/24/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the therapist.</p> <p>6. The undated policy titled "C-360 Coordination of Client Services" states, "1. Care conferences will be held as necessary to establish interchange, reporting and coordinated evaluation between all disciplines involved in the client's care. 4. Ongoing care conferences shall be conducted to evaluate the client's status and progress ... 6. Care conferences will be documented on the Care Conference Summary form or in the progress notes."</p> <p>7. On 1/20/11 at 10:00 AM, the director of nursing indicated case conferences were conducted between disciplines but were not documented.</p>						