

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 02/13/2014
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NAME OF PROVIDER OR SUPPLIER  PREMIER HOMECARE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9190 PRIORITY WAY W DR STE 112 INDIANAPOLIS, IN 46240
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G000000	<p>This visit was an initial home health certification survey.</p> <p>Survey dates: February 13, 14, 17, and 18, 2014</p> <p>Facility #12581-1</p> <p>Surveyors: Shannon Pietraszewski RN, PH Nurse Surveyor</p> <p>Census: 11 Home visits: 2</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 24, 2014</p>	G000000		
G000143	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p>	G000143	On 02.26.2014 staff education regarding importance and	02/26/2014

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>Based on clinical record and policy review and interview, the agency failed to ensure all personnel furnishing services communicated to ensure coordination of care while services were being provided for 2 of 5 records reviewed. This had the potential to affect all patients who received more than one service or service from another provider. (#2 and 4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a visit note written by a physical therapist on 08/29/13. The note stated the patient injured her left hand while opening her window on the previous day. The record failed to evidence any communication with the case manager.</li> <li>2. Clinical record number 4 included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14 that identified that the patient received hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</li> <li>3. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional</li> </ol>		<p>requirements of care coordination with outside facilities, of reporting a change in patient condition, of interdisciplinary care coordination was conducted by the DCS . The involved contract therapist was individually instructed on the importance and requirement of promptly reporting any changes in patient condition to the RN case manager for follow-up with the physician. On 02.17.2014 the contract therapist was instructed on the need for the physician to be promptly alerted to any changes in the patient's condition. On 02.17.2014 the RN Case Manager was instructed on the requirement to promptly notify the physician of changes in the patient's condition. The instruction was documented and placed in the contract PT's file. The incident of the care coordination with the dialysis facility was specifically instructed to the staff on 02.26.2014 and the RN Case Manager on 02.17.2014. Staff education was documented and file in each employees file. Care Coordination is included in the mandatory annual education and also in the orientation program. A new form was developed 02.26.2014 for case conferences that includes a category for care coordination and changes in condition. The form will be completed at the scheduled case conferences to document changes, physician notification</p>	

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G000144	<p>documentation and/or information when asked on 02/18/14 at 11:30 PM.</p> <p>4. A policy titled "Coordination of Client Services", undated, stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction ... Interdisciplinary Care Conferences will be held as necessary to establish interchange and reporting, to coordinate evaluations between involved disciplines, to respond to changes in the client's needs, services, care or goals."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record and policy</p>			G000144	<p>and filed in the patient's chart. Contact with and coordination of services with outside facilities will be documented on this form. The Case Conference Summary will be reviewed for completeness prior to being filed. 02.26.2014 the other current charts were audited to insure this standard was met. This standard is incorporated in the ongoing and quarterly audits and will continue to be monitored on an ongoing basis and continue to be incorporated into the QA/PI program. If the compliance level is less than 100% then re-education will be instituted. The director of clinical services is responsible for the compliance of this standard and the implementation of the corrective measures.</p> <p>On 02.26.2014 staff education</p>		02/26/2014

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	<p>review and interview, the agency failed to ensure all personnel furnishing services communicated to ensure coordination of care while services were being provided for 2 of 5 records reviewed. This had the potential to affect all patients who received more than one service or service from another provider. (#2 and 4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a visit note written by a physical therapist on 08/29/13. The note stated the patient injured her left hand while opening her window on the previous day. The record failed to evidence any communication with the case manager.</li> <li>2. Clinical record number 4 included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14 that identified that the patient received hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</li> <li>3. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when</li> </ol>		<p>regarding importance and requirements of care coordination with outside facilities, of reporting a change in patient condition, of interdisciplinary care coordination was conducted by the DCS . The involved contract therapist was individually instructed on the importance and requirement of promptly reporting any changes in patient condition to the RN case manager for follow-up with the physician. On 02.17.2014 the contract therapist was instructed on the need for the physician to be promptly alerted to any changes in the patient's condition. The RN Case Manager was instructed on the requirement to promptly notify the physician of changes in the patient's condition. The instruction was documented and placed in the contract PT's file. The incident of the care coordination with the dialysis facility was specifically instructed to the staff on 02.26.2014 and the RN Case Manager on 02.17.2014. Staff education was documented and file in each employees file. Care Coordination is included in the mandatory annual education and also in the orientation program. A new form was developed 02.26.2014 for case conferences that includes a category for care coordination and changes in condition. The form will used at the scheduled case conferences to document changes, physician notification and filed in the patient's chart.</p>				

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	asked on 02/18/14 at 11:30 PM.  4. A policy titled "Coordination of Client Services", undated, stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction ... Interdisciplinary Care Conferences will be held as necessary to establish interchange and reporting, to coordinate evaluations between involved disciplines, to respond to changes in the client's needs, services, care or goals."		Contact with and coordination of services with outside facilities will be documented on this form. 02.26.2014 the other current charts were audited to insure this standard was met. This standard is incorporated in the ongoing and quarterly audits and will continue to be monitored on an ongoing basis and continue to be incorporated into the QA/PI program. If the compliance level is less than 100% then re-education will be instituted. The director of clinical services is responsible for the compliance of this standard and the implementation of the corrective measures.				

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G000159	<p>484.18(a) PLAN OF CARE</p> <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 and policy review and interview, the agency failed to ensure the Plan of Care included all pertinent diagnoses, types of services, and treatments for 1 of 5 clinical records reviewed. This had the potential to affect all 11 patients who received services within the agency. (#4)</p> <p>Findings include:</p> <p>1. Clinical record number 4 included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14. The comprehensive assessment upon admission stated the patient had a diagnoses of congestive heart failure, venous insufficiency, lower extremity edema, lower extremity wound, end stage renal disease and diabetes mellitus. The comprehensive assessment included the patient had abdominal ascites and received</p>	G000159	02.26.2014 the involved clinicians were instructed on the need for complete and accurate POC reflective of the comprehensive assessment. The specific educational example of the dialysis, paracentesis, ascites patient was instructed. On 02.17.2014 the physician was contacted and the POC updated including the diagnosis of Ascites and appropriate interventions related to the ascites. The RN case manager was instructed on the requirement for the POC to be complete and accurate reflecting the pertinent diagnosis, services, and treatments. For 6 months all SOC's will be audited for completeness of the comprehensive assessment and that the POC accurately reflects the patient's assessed needs and status, all pertinent diagnosis, services, and treatments. This PI project, Plan of Care/Comprehensive Assessment, will be incorporated QA/PI program. A	02/26/2014			

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G000164	<p>paracentesis every month. The clinical record failed to evidence the Plan of Care included a diagnosis for the abdominal ascites, monthly paracentesis, and monitoring for abdominal girth with ranges for physician notification.</p> <p>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</p> <p>3. A policy titled "Plan of Care" (undated) stated, "The Plan of Care shall be completed in full to include the client's assessed needs: a. All pertinent diagnosis(es), principle and secondary, including dates of onset ... surgical procedures(s) ... Medications, treatments, and procedures ... "</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record and policy review and interview, the agency failed to ensure the physician was notified of a change in a patient's condition for 1 of 5</p>	G000164	<p>compliance level of 100% is assigned to the project. Monitoring through ongoing/quarterly audits will continue and be incorporated into the QA/PI program with a 100% compliance level expected. Re-education will be instituted as indicated by the outcome of the audits. The Director of Clinical Services is responsible for compliance with this standard and the implementation of corrective measures.</p> <p>On 02.26.2014 staff education regarding care coordination with the physician, reporting any change in patient condition or status, interdisciplinary care</p>	02/26/2014			

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	<p>records reviewed. This had the potential to affect all 11 patients who received care with the agency. (#2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a visit note written by a physical therapist on 08/29/13. The note identified the patient injured her left hand while opening her window on the previous day. The record failed to evidence any communication with the patient's physician.</li> <li>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</li> <li>3. A policy titled "Medical Supervision" (undated) stated, "Agency Responsibilities include: Prompt reporting of a change in client condition ... "</li> </ol>		<p>coordination requirements was instructed. On 02.17.2014 the involved contract therapist was individually instructed on promptly reporting changes in patient condition to the RN case manager for follow-up with the physician. 02.17.2014 the contract therapist was instructed on the importance and requirement of promptly alerting the physician to any changes in the patient's condition or status. The instruction was documented and in the contract PT's file. The RN Case Manager was instructed on the requirement of promptly reporting changes in the patient's condition to the physician. Care Coordination policy including the notification of the physician regarding patient condition change is included in the mandatory annual education and orientation which includes contract staff. The involved therapist is attending the scheduled case conferences and does participate in reporting on patient status. Any changes in the patient condition will be documented on the case conference summary and notification of the physician will be documented in the patient file. Contract therapy visit reports will be reviewed prior to being filed. The other current charts were audited to insure this standard was met on 02.26.2014. This standard is included on the ongoing/quarterly audits and is</p>				

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G000166	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on clinical record review and interview, the agency failed to ensure verbal physician orders were put in writing, signed, and dated by the registered nurses for 2 of 5 records reviewed creating the potential to affect all of the agency's 11 current patients. (# 4 and 5)</p> <p>The findings include:</p> <p>1. Clinical record number 4 start of care 12/21/13 included an order dated 01/30/14 for social services to "evaluate and provide intervention for noncompliance, community resources &amp; [and] real expectations of disease</p>	G000166	<p>incorporated into the QA/PI program. Ongoing monitoring will occur with a compliance level of 100%. Re-education will be instituted as indicated by the outcome of the audits. The The Director of Clinical Services is responsible for the compliance of this standard and the implementation of the corrective meausres.</p> <p>Investigation with MSW revealed that due to severe incimate weather MSW was unable to make initial evaluation for the patient. 03.04.2014 the MSW was instructed that if unable to make appointments the patient, RN Case Manager, and physician need to be informed. An order was sent to the physician on 2.12.2014 to discontinue the MSW as patient's needs were resolved. The RN Case Manager was instructed on 02.26.2014 regarding the POC policy and procedure including the need to insure all verbal orders are documented and signed by the physician in a timely manner. 01.08.2014 an order to the physician was sent to DC the Benazepril. 02.26.2014 staff</p>	03/12/2014			

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	<p>process, to begin week of 02/02/14." The record failed to evidenced social service had contacted the patient. The record failed to evidence an order had been written to stop the social work services.</p> <p>2. Clinical record number 5 start of care 12/17/14 included a visit note by a registered nurse on 12/24/13 and 12/31/13 that stated the patient's benazepril (blood pressure pill) continued to be on hold. The medication profile indicated the medication had been on hold since 12/24/13 and discontinued on 01/08/14. The record failed to evidence a hold and discontinued order had been written.</p> <p>3. The Director of Nursing and employee A, a registered nurse, indicated, on 02/18/14 at 11:30 AM, the patient changed his mind and refused social services. Employee A indicated she had forgotten to write the order to discontinue the social service and thought she had thought she had written the order to discontinue the benazepril.</p> <p>4. A policy titled "Physician orders" (undated) stated, "When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given and then read the order</p>		<p>education included the need to confirm orders with the physician for on hold meds and put into writing the hold order for the physician to sign and date. Compliance with this standard is included in the PI project POC/Comprehensive Assessment/Orders. For 6 months beginning 02.26.2014 100% of SOC, Resumptions, and Recertifications will be audited for compliance with this standard. 100% compliance is the expectation. This standard will continue to be audited ongoingly thorough quarterly audits. Re-education will be conducted based on the outcome of the audits.</p>	

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G000173	<p>back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review and interview, the agency failed to ensure a Registered Nurse made necessary revisions on a plan of care for 1 of 5 records reviewed. This had the potential for affect all patients receiving services from this agency. (#4)</p> <p>Findings include:</p> <p>1. Clinical record number 4 included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14. The comprehensive assessment dated 12/21/13 upon admission stated the patient had a diagnoses of congestive heart failure, venous insufficiency, lower extremity edema, lower extremity wound, end stage renal disease and diabetes mellitus. The comprehensive assessment included the patient had abdominal ascites and received paracentesis every month. The</p>	G000173	02.26.2014 the involved clinicians were instructed on the need for complete and accurate POC reflective of the comprehensive assessment. The specific educational example of the dialysis, paracentesis, ascites patient was instructed. On 02.17.2014 the physician was contacted and the POC updated including the diagnosis of Ascites and appropriate interventions related to the ascites. The RN case manager was instructed on the requirement for the POC to be complete and accurate reflecting the pertinent diagnosis, services, and treatments. For 6 months all SOC's will be audited for completeness of the comprehensive assessment and that the POC accurately reflectives the patient's assessed needs and status, all pertinent diagnosis, services, and treatments. This PI project, Plan of Care/Comprehensive Assessment/Orders will be incorporated QA/PI program. A	02/26/2014

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G000176	<p>clinical record failed to evidence the registered nurse revised the plan of care to include a diagnosis for the abdominal ascites, abdominal paracentesis every month, and monitoring for abdominal girth with ranges for physician notification.</p> <p>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had maintained communication with other service providers for 1 of 5 records reviewed and informed the physician of changes in the patients condition for 1 of 5 records reviewed. This had the potential to affect all 11 patients who were receiving care in the agency. (# 2</p>	G000176	<p>compliance level of 100% is assigned to the project. Monitoring through the ongoing/quarterly audits will continue and be incorporated into the QA/PI program with a 100% compliance level expected. Re-education will be instituted as indicated by the outcome of the audits. The Director of Clinical Services is responsible for compliance with this standard and the implementation of corrective measures.</p> <p>02.26.2014 Staff education regarding importance and requirements of care coordination with outside facilities, of promptly reporting a change in patient condition, of interdisciplinary care coordination. The involved contract therapist was individually instructed on the importance and requirement of reporting promptly any changes in patient condition to the RN case manager for follow-up with the</p>	02/26/2014

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	<p>and 4)</p> <p>The findings include:</p> <p>Related to maintained communication</p> <p>1. Clinical record number 4 included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14 that identified that the patient received hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</p> <p>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</p> <p>3. A policy titled "Coordination of Client Services", undated, stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction ... Interdisciplinary Care Conferences will be held as necessary to establish</p>		<p>physician. The instruction was documented and placed in the contract PT's file. The RN Case Manager was instructed on the policy of reporting promptly to the physician any changes in the patient's condition and to maintain constant liaisons with therapy. The incident of the care coordination with the dialysis facility was specifically instructed to the staff on 02.26.2014 and RN Case Manager. The duties and requirements of the RN Case Manager were instructed to the involved RN on 02.17.2014. Staff education was documented and filed in the employee's file. Care Coordination is included in the mandatory annual education and also in the orientation program. A new form was developed 02.26.2014 for case conferences that includes a category for care coordination. The form will used at the every other week scheduled case conferences and filed in the patient's chart. Contact with and coordination of services with outside facilities will be documented on this form. 02.26.2014 the other current charts were audited to insure this standard was met. Visit reports will be reviewed prior to being filed by the DCS to insure this standard is met. This standard is incorporated in the ongoing and quarterly audits and will continue to be monitored on an ongoing basis and continue to be incorporated into the QA/PI</p>				

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	<p>interchange and reporting, to coordinate evaluations between involved disciplines, to respond to changes in the client's needs, services, care or goals."</p> <p>Related to informing the physician</p> <p>1. Clinical record number 2 included a visit note written by a physical therapist on 08/29/13. The note identified the patient injured her left hand while opening her window on the previous day. The record failed to evidence any communication with the patient's physician.</p> <p>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</p> <p>3. A policy titled "Medical Supervision" (undated) stated, "Agency Responsibilities include: Prompt reporting of a change in client condition ... "</p>		<p>program. If the compliance level is less than 100% then re-education will be instituted. The director of clinical services is responsible for the compliance of this standard and the implementation of the corrective measures.</p>				

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G000188	<p>484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure physical therapy notified the case manager of a patient's injury for 1 of 5 records reviewed. This had the potential to affect all 11 patients receiving services from the agency. (#5)</p> <p>Finding include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a visit note written by a physical therapist on 08/29/13. The note stated the patient injured her left hand while opening her window on the previous day. The record failed to evidenced the physical therapist notified the case manager of the patient's injury to her hand.</li> <li>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</li> <li>3. A policy titled "Therapy Services" (undated) stated "The qualified therapist: Assists the physician in evaluating level of function and advises and consults with the family and other agency</li> </ol>	G000188	<p>02.26.2014 Staff education regarding care coordination with the physician, reporting any change in patient condition or status, interdisciplinary care coordination requirements. On 02.17.2014 the involved contract therapist was individually instructed on promptly reporting changes in patient condition to the RN case manager for follow-up with the physician. 02.17.2014 the contract therapist was instructed on the importance and requirement of alerting the physician to any changes in the patient's condition or status. The instruction was documented and in the contract PT's file. The RN Case Manager was instructed on the need to maintain liasion with contract staff and promptly alert the physician to any changes in the patient's condition. Care Coordination policy including the prompt notification of the physician regarding patient condition change is included in the mandatory annual education and orientation which includes contract staff. The involved therapist is attending the scheduled case conferences and does participate in reporting on patient status. Any changes in the patient condition will be documented on the case conference summary and</p>	02/26/2014			

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G000331	<p>personnel ... "</p> <p>4. A policy titled "Medical Supervision" (undated) stated, "Agency Responsibilities include: Prompt reporting of a change in client condition ... "</p> <p>484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record and policy review and interview, the agency failed to ensure the Endocrine/Hematology was assessed and measured upon admission for 1 of 5 clinical records reviewed. This had the potential to affect all current 11 patients admitted to the agency. (#4)</p> <p>Findings include:</p>	G000331	<p>notification of the physician will be documented in the patient file. Contract therapy visit reports will be reviewed before being filed. The other current charts were audited to insure this standard was met on 02.26.2014. This standard is included on the ongoing/quarterly audits and is incorporated into the QA/PI program. Ongoing monitory will occur with a compliance level of 100%. Re-education will be instituted as indicated by the outcome of the audits. The The Director of Clinical Services is responsible for the compliance of this standard and the implementation of the corrective meausres.</p> <p>02.17.014 review of the patient's file with the RN Case Manager was conducted. The initial assessment indicates under the Edcocrine/Hematology section the patient is "diet controlled diabetic." Nothing further is documented regarding the diabetic interventions. 03.04.2014 the RN completing the initial assessment was instructed that further investigation with the ALF and physician should have been</p>	02/26/2014			

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	<p>1. Clinical record number 4, start of care 12/21/13, included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14 that included orders for skilled nursing to teach diabetic foot care including monitoring for the presence of skin lesion and instruct on control of health problems, disease process, and diet. The compressive assessment dated 12/21/13 failed to evidence the blood sugars, frequency of monitoring, blood sugar ranges, competency with use of the glucometer, and that a diabetic foot exam had been assessed upon admission.</p> <p>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</p> <p>3. A policy titled "Comprehensive Assessment", undated, stated, "The assessments identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems. The depth and frequency of ongoing assessments will depend on client needs, goals, and the care treatment and services provided ... To collect data about the client's health history, physical functional and</p>		<p>conducted to confirm interventions needed to manage the diabetes. The RN was instructed this contact and outcome should have been documented and included on the POC. 02.26.2014 staff was educated on the same. PI project, Plan of Care/Comprehensive Assessment/Orders will monitor this standard for 6 mos. Ongoing monitoring will occur with the quarterly audits. 100% compliance is the expectation. Re-education will be conducted based on the outcome of audits. The Director of Clinical services is responsible for compliance with this standard and implementation of the corrective measures.</p>	

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N000000	<p>psychological status/needs and their needs as appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each client's needs and the individuals response to care ... "</p> <p>This visit was a home health re-licensure survey.</p> <p>Survey dates: February 13, 14, 17, and 18, 2014</p> <p>Facility #12581-1</p> <p>Surveyors: Shannon Pietraszewski RN, PH Nurse Surveyor Nina Koch, RN, PHNS</p> <p>Census: 11 Home visits: 2</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 24, 2014</p>	N000000					

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N000484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record and policy review and interview, the agency failed to ensure all personnel furnishing services communicated to ensure coordination of care while services were being provided for 1 of 5 records reviewed. This had the potential to affect all patients who received more than one service with the agency. (#2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a visit note written by a physical therapist on 08/29/13. The note stated the patient injured her left hand while opening her window on the previous day. The record failed to evidence any communication with the case manager.</li> <li>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</li> </ol>	N000484	<p>On 02.26.2014 staff education regarding care coordination with the physcian, reporting any change in patient condition or status, interdisciplinary care coordination requirements was conducted by theDCS. On 02.17.2014 the involved contract therapist was individually instructed on promptly reporting changes in the patient condition to the RN case manager for prompt follow-up with the physician. 02.17.2014 the contract therapist was instructed on the importance and requirement of promptly alerting the physician to any changes in the patient's condition or status. The instruction was documented and in the contract PT's file. 02.17.2014 the RN Case Manager was instructed on maintaining liaison with the contracted therapy and the requirement of promptly reporting to the physician changes in the patient's condition. Care Coordination policy including the notification of the physician regarding patient condition change is included in the</p>	02/26/2014			

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N000486	<p>3. A policy titled "Coordination of Client Services" (undated), stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction ... Interdisciplinary Care Conferences will be held as necessary to establish interchange and reporting, to coordinate evaluations between involved disciplines, to respond to changes in the client's needs, services, care or goals."</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure all communicated with other providers furnishing services for 1 of 5</p>	N000486	<p>mandatory annual education and orientation which includes contract staff. The involved therapist is attending the scheduled case conferences and does participate in reporting on patient status. Any changes in the patient condition will be documented on the case conference summary and notification of the physician will be documented in the patient file. Contract therapy visit reports will be reviewed prior to being filed to insure prompt reporting. The other current charts were audited to insure this standard was met on 02.26.2014. This standard is included on the ongoing/quarterly audits and is incorporated into the QA/PI program. Ongoing monitorinh will occur with a compliance level of 100%. Re-education will be instituted as indicated by the outcome of the audits. The The Director of Clinical Services is responsible for the compliance of this standard and the implementation of the corrective meausres.</p> <p>On 02.26.2014 Staff education regarding importance and requirements of care coordination with outside facilities, of reporting a change in patient condition, of interdisciplinary care coordination.</p>	02/26/2014			

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	<p>records reviewed. This had the potential to affect all patients who received services from another provider. (# 4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 4 included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14 that identified that the patient received hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</li> <li>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</li> <li>3. A policy titled "Coordination of Client Services", undated, stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction ... Interdisciplinary Care Conferences will</li> </ol>		<p>The involved contract therapist was individually instructed on the importance and requirement of reporting any changes in patient condition to the RN case manager for follow-up with the physician. The instruction was documented and placed in the contract PT's file. The incident of the care coordination with the dialysis facility was specifically instructed to the staff on 02.26.2014 and to the RN Case Manager on 02.17.2014. Staff education was documented and file in each employees file. Care Coordination is included in the mandatory annual education and also in the orientation program. A new form was developed 02.26.2014 for case conferences that includes a category for care coordination. The form will be completed at the scheduled case conferences and filed in the patient's chart. Contact with and coordination of services with outside facilities will be documented on this form. 02.26.2014 the other current charts were audited to insure this standard was met. This standard is incorporated in the ongoing and quarterly audits and will continue to be monitored on an ongoing basis and continue to be incorporated into the QA/PI program. If the compliance level is less than 100% then re-education will be instituted. The director of clinical services is responsible for the compliance of</p>				

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N000524	<p>be held as necessary to establish interchange and reporting, to coordinate evaluations between involved disciplines, to respond to changes in the client's needs, services, care or goals."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record and policy review and interview, the agency failed to ensure the Plan of Care included all pertinent diagnoses, types of services, and treatments for 1 of 5 clinical records</p>	N000524	<p>this standard and the implementation of the corrective measures.</p> <p>02.26.2014 the involved clinicians were instructed on the need for complete and accurate POC reflective of the comprehensive assessment. The specific educational example of the</p>	02/26/2014

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	<p>reviewed. This had the potential to affect all 11 patients who received services within the agency. (#4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 4 included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14. The comprehensive assessment upon admission stated the patient had a diagnoses of congestive heart failure, venous insufficiency, lower extremity edema, lower extremity wound, end stage renal disease and diabetes mellitus. The comprehensive assessment included the patient had abdominal ascites and received paracentesis every month. The clinical record failed to evidence the Plan of Care included a diagnosis for the abdominal ascites, monthly paracentesis, and monitoring for abdominal girth with ranges for physician notification.</li> <li>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</li> <li>3. A policy titled "Plan of Care" (undated) stated, "The Plan of Care shall be completed in full to include the</li> </ol>		<p>dialysis, paracentesis, ascites patient was instructed. On 02.17.2014 the physician was contacted and the POC updated including the diagnosis of Ascites and appropriate interventions related to the ascites. The RN case manager was instructed on the requirement for the POC to be complete and accurate reflecting the pertinent diagnosis, services, and treatments. For 6 months all SOC's will be audited for completeness of the comprehensive assessment and that the POC accurately reflectives the patient's assessed needs and status, all pertinent diagnosis, services, and treatments. This PI project will be incorporated QA/PI program. A compliance level of 100% is assigned to the project. Monitoring through the SOC and ongoing/quarterly audits will continue and be incorporated into the QA/PI program with a 100% compliance level expected. Re-education will be instituted as indicated by the outcome of the audits. The Director of Clinical Services is responsible for compliance with this standard and the implementation of corrective measures.</p>				

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N000527	<p>client's assessed needs: a. All pertinent diagnosis(es), principle and secondary, including dates of onset ... surgical procedures(s) ... Medications, treatments, and procedures ... "</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on clinical record and policy review and interview, the agency failed to ensure the physician was notified of a change in a patient's condition for 1 of 5 records reviewed. This had the potential to affect all 11 patients who received care with the agency. (#2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a visit note written by a physical therapist on 08/29/13. The note identified the patient injured her left hand while opening her window on the previous day. The record failed to evidence any communication with the patient's physician.</li> <li>2. The Director of Nursing and</li> </ol>	N000527	<p>On 02.26.2014 staff education regarding care coordination with the physician, reporting any change in patient condition or status, interdisciplinary care coordination requirements was instructed. On 02.17.2014 the involved contract therapist was individually instructed on promptly reporting changes in patient condition to the RN case manager for follow-up with the physician. 02.17.2014 the contract therapist was instructed on the importance and requirement of promptly alerting the physician to any changes in the patient's condition or status. The instruction was documented and in the contract PT's file. The RN Case Manager was instructed on the requirement of promptly reporting changes in the patient's condition to the physician. Care Coordination policy including the</p>	02/26/2014

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N000540	<p>Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</p> <p>3. A policy titled "Medical Supervision" (undated) stated, "Agency Responsibilities include: Prompt reporting of a change in client condition ..."</p> <p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on clinical record and policy</p>			N000540	<p>notification of the physician regarding patient condition change is included in the mandatory annual education and orientation which includes contract staff. The involved therapist is attending the scheduled case conferences and does participate in reporting on patient status. Any changes in the patient condition will be documented on the case conference summary and notification of the physician will be documented in the patient file. Contract therapy visit reports will be reviewed prior to being filed. The other current charts were audited to insure this standard was met on 02.26.2014. This standard is included on the ongoing/quarterly audits and is incorporated into the QA/PI program. Ongoing monitoring will occur with a compliance level of 100%. Re-education will be instituted as indicated by the outcome of the audits. The The Director of Clinical Services is responsible for the compliance of this standard and the implementation of the corrective measures.</p> <p>02.17.014 review of the patient's</p>		02/26/2014

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	<p>review and interview, the agency failed to ensure the registered nurse assessed and measured Endocrine/Hematology upon admission for 1 of 5 clinical records reviewed. This had the potential to affect all current 11 patients admitted to the agency. (#4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 4, start of care 12/21/13, included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14 that included orders for skilled nursing to teach diabetic foot care including monitoring for the presence of skin lesion and instruct on control of health problems, disease process, and diet. The compressive assessment dated 12/21/13 failed to evidence the blood sugars, frequency of monitoring, blood sugar ranges, competency with use of the glucometer, and that a diabetic foot exam had been assessed upon admission.</li> <li>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</li> <li>3. A policy titled "Comprehensive</li> </ol>		<p>file with the RN Case Manager was conducted. The initial assessment indicates under the Eddocrine/Hematology section the patient is "diet controlled diabetic." Nothing further is documented regarding the diabetic interventions. 03.04.2014 the RN completing the initial assessment was instructed that further investigation with the ALF and physician should have been conducted to confirm interventions needed to manage the diabetes. The RN was instructed this contact and outcome should have been documented and included on the POC. 02.26.2014 staff was educated on the same. PI project, Plan of Care/Comprehensive Assessment/Orders will monitor this standard for 6 mos. Ongoing monitoring will occur with the quarterly audits. 100% compliance is the expectation. Re-education will be conducted based on the outcome of audits. The Director of Clinical services is responsible for compliance with this standard and implementation of the corrective measures.</p>	

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N000542	<p>Assessment", undated, stated, "The assessments identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems. The depth and frequency of ongoing assessments will depend on client needs, goals, and the care treatment and services provided ... To collect data about the client's health history, physical functional and psychological status/needs and their needs as appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each client's needs and the individuals response to care ... "</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services 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 review and interview, the agency failed to ensure a Registered Nurse made necessary revisions on a plan of care for 1 of 5 records reviewed. This had the potential for affect all patients receiving services from this agency. (#4)</p> <p>Findings include:</p>	N000542	02.26.2014 the involved clinicians were instructed on the need for complete and accurate POC reflective of the comprehensive assessment. The specific educational example of the dialysis, paracentesis, ascites patient was instructed. On 02.17.2014 the physician was contacted and the POC updated including the diagnosis of Ascites and appropriate interventions	02/26/2014

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N000545	<p>1. Clinical record number 4 included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14. The comprehensive assessment dated 12/21/13 upon admission stated the patient had a diagnoses of congestive heart failure, venous insufficiency, lower extremity edema, lower extremity wound, end stage renal disease and diabetes mellitus. The comprehensive assessment included the patient had abdominal ascites and received paracentesis every month. The clinical record failed to evidence the registered nurse revised the plan of care to include a diagnosis for the abdominal ascites, abdominal paracentesis every month, and monitoring for abdominal girth with ranges for physician notification.</p> <p>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM. 410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p>		<p>related to the ascites. The RN case manager was instructed on the requirement for the POC to be complete and accurate reflecting the pertinent diagnosis, services, and treatments. For 6 months all SOC's will be audited for completeness of the comprehensive assessment and that the POC accurately reflectives the patient's assessed needs and status, all pertinent diagnosis, services, and treatments. This PI project will be incorporated QA/PI program. A compliance level of 100% is assigned to the project. Monitoring through the SOC and ongoing/quarterly audits will continue and be incorporated into the QA/PI program with a 100% compliance level expected. Re-education will be instituted as indicated by the outcome of the audits. The Director of Clinical Services is responsible for compliance with this standard and the implementation of corrective measures.</p>	

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had maintained communication with other service providers for 1 of 5 records reviewed. This had the potential to affect all patients who were receiving care from other providers. (# 4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 4 included a plan of care established by the physician for the certification period 12/21/13 to 02/18/14 that identified that the patient received hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</li> <li>2. The Director of Nursing and employee A, a registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</li> <li>3. A policy titled "Coordination of Client Services" (undated), stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through</li> </ol>	N000545	<p>02.26.2014 Staff education regarding importance and requirements of care coordination with outside facilities, of reporting a change in patient condition, of interdisciplinary care coordination. The incident of the care coordination with the dialysis facility was specifically instructed to the staff on 02.26.2014 and to the RN Case Manager on 02.17.2014. Staff education was documented and file in each employees file. Care Coordination is included in the mandatory annual education and also in the orientation program. A new form was developed 02.26.2014 for case conferences that includes a category for care coordination. The form will be completed at the scheduled case conferences and filed in the patient's chart. Contact with and coordination of services with outside facilities will be documented on this form. 02.26.2014 the other current charts were audited to insure this standard was met. This standard is incorporated in the ongoing and quarterly audits and will continue to be monitored on an ongoing basis and continue to be incorporated into the QA/PI program. If the compliance level is less than 100% then re-education will be instituted. The director of clinical services is responsible for the compliance of this standard and the implementation of the corrective measures.</p>	02/26/2014			

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N000546	<p>formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction ... Interdisciplinary Care Conferences will be held as necessary to establish interchange and reporting, to coordinate evaluations between involved disciplines, to respond to changes in the client's needs, services, care or goals."</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse notified the physician of a change in a patient's condition for 1 of 5 records reviewed. This had the potential to affect all 11 patients who received care with the agency. (#2)</p>	N000546	On 02.26.2014 Staff education regarding care coordination with the physician, reporting any change in patient condition or status, interdisciplinary care coordination requirements was conducted by the DCS. On 02.17.2014 the involved contract therapist was individually instructed on promptly reporting changes in patient condition to	02/26/2014

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	<p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a visit note written by a physical therapist on 08/29/13. The note identified the patient injured her left hand while opening her window on the previous day. The record failed to evidence any communication with the patient's physician.</li> <li>2. The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</li> <li>3. A policy titled "Medical Supervision" (undated) stated, "Agency Responsibilities include: Prompt reporting of a change in client condition ... "</li> </ol>		<p>the RN case manager for follow-up with the physician. On 02.17.2014 the contract therapist was instructed on the importance and requirement of alerting the physician to any changes in the patient's condition or status and to immediately report changes to the RN Case Manager. The instruction was documented and in the contract PT's file. The RN Case Manager was instructed on the requirement of notifying the physician promptly of any changes in the patient condition. Care Coordination policy including the notification of the physician regarding patient condition change is included in the mandatory annual education and orientation which includes contract staff. The involved therapist is attending the scheduled case conferences and does participate in reporting on patient status. Any changes in the patient condition will be documented on the case conference summary and notification of the physician will be documented in the patient file. Contract therapy visit reports will be reviewed prior to being filed to insure that documented changes in patient condition are promptly relayed to the RN Case Manager. The other current charts were audited to insure this standard was met on 02.26.2014. This standard is included on the ongoing/quarterly audits and is incorporated into the QA/PI</p>				

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N000547	<p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on clinical record review and interview, the agency failed to ensure verbal physician orders were put in writing, signed, and dated by the registered nurses for 2 of 5 records reviewed creating the potential to affect all of the agency's 11 current patients. (# 4 and 5)</p> <p>The findings include:</p> <p>1. Clinical record number 4 start of care 12/21/13 included an order dated 01/30/14 for social services to "evaluate and provide intervention for noncompliance, community resources &amp; [and] real expectations of disease process, to begin week of 02/02/14."</p>	N000547	<p>program. Ongoing monitoring will occur with a compliance level of 100%. Re-education will be instituted as indicated by the outcome of the audits. The Director of Clinical Services is responsible for the compliance of this standard and the implementation of the corrective measures.</p> <p>Investigation with MSW revealed that due to severe incimate weather MSW was unable to make initial evaluation for the patient. 03.04.2014 the MSW was instructed that if unable to make appointments the patient, RN Case Manager, and physician need to be informed. An order was sent to the physician on 2.12.2014 to discontinue the MSW as patient's needs were resolved. The RN Case Manager was instructed on 02.26.2014 regarding the POC policy and procedure including the need to insure all verbal orders are documented and signed by the physician in a timely manner. 01.08.2014 an order to the physician was sent to DC the Benazepril. 02.26.2014 staff</p>	02/26/2014			

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	<p>The record failed to evidenced social service had contacted the patient. The record failed to evidence an order had been written to stop the social work services.</p> <p>2. Clinical record number 5 start of care 12/17/14 included a visit note by a registered nurse on 12/24/13 and 12/31/13 that stated the patient's benazepril (blood pressure pill) continued to be on hold. The medication profile indicated the medication had been on hold since 12/24/13 and discontinued on 01/08/14. The record failed to evidence a hold and discontinued order had been written.</p> <p>3. The Director of Nursing and employee A, a registered nurse, indicated, on 02/18/14 at 11:30 AM, the patient changed his mind and refused social services. Employee A indicated she had forgotten to write the order to discontinue the social service and thought she had thought she had written the order to discontinue the benazepril.</p> <p>4. A policy titled "Physician orders" (undated) stated, "When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the</p>		<p>education included the need to confirm orders with the physician for on hold meds and put into writing the hold order for the physician to sign and date. Compliance with this standard is included in the PI project POC/Comprehensive Assessment/Orders. For 6 months beginning 02.26.2014 100% of SOC, Resumptions, and Recertifications will be audited for compliance with this standard. 100% compliance is the expectation. This standard will continue to be audited ongoingly thorough quarterly audits. Re-education will be conducted based on the outcome of the audits.</p>				

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N000567	<p>person receiving the order heard it correctly and interpreted the order correctly ... "</p> <p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on clinical record and policy review and interview, the agency failed to ensure physical therapy notified the case manager of a patient's injury for 1 of 5 records reviewed. This had the potential to affect all 11 patients receiving services from the agency. (#5)</p> <p>Finding include:</p> <ol style="list-style-type: none"> <li>Clinical record number 2 included a visit note written by a physical therapist on 08/29/13. The note stated the patient injured her left hand while opening her window on the previous day. The record failed to evidenced the physical therapist notified the case manager of the patient's injury to her hand.</li> <li>The Director of Nursing and Employee A, registered nurse, were unable to provide any additional documentation and/or information when asked on 02/18/14 at 11:30 PM.</li> </ol>	N000567	<p>On 02.26.2014 Staff education regarding care coordination with the physician, reporting any change in patient condition or status, interdisciplinary care coordination requirements was conducted by the DCS. On 02.17.2014 the involved contract therapist was individually instructed on promptly reporting changes in patient condition to the RN case manager for follow-up with the physician. On 02.17.2014 the contract therapist was instructed on the importance and requirement of alerting the physician to any changes in the patient's condition or status and to immediately report changes to the RN Case Manager. The instruction was documented and in the contract PT's file. The RN Case Manager was instructed on the requirement of notifying the physician promptly of any changes in the patient condition. Care Coordination policy including the notification of the physician regarding patient condition change is included in the mandatory annual education</p>	02/26/2014

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	<p>3. A policy titled "Therapy Services" (undated) stated, "The qualified therapist: Assists the physician in evaluating level of function and advises and consults with the family and other agency personnel ... "</p> <p>4. A policy titled "Medical Supervision" (undated) stated, "Agency Responsibilities include: Prompt reporting of a change in client condition ... "</p>		<p>and orientation which includes contract staff. The involved therapist is attending the scheduled case conferences and does participate in reporting on patient status. Any changes in the patient condition will be documented on the case conference summary and notification of the physician will be documented in the patient file. Contract therapy visit reports will be reviewed prior to being filed to insure that documented changes in patient condition are promptly relayed to the RN Case Manager. The other current charts were audited to insure this standard was met on 02.26.2014. This standard is included on the ongoing/quarterly audits and is incorporated into the QA/PI program. Ongoing monitoring will occur with a compliance level of 100%. Re-education will be instituted as indicated by the outcome of the audits. The Director of Clinical Services is responsible for the compliance of this standard and the implementation of the corrective measures.</p>		