

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	<p>This visit was for a federal home health agency complaint investigation survey. This was an extended survey.</p> <p>Complaint #IN00099134 - Unsubstantiated: Lack of sufficient evidence. Unrelated conditions of participation and standard level deficiencies were cited.</p> <p>Survey Date: December 5, 2011</p> <p>Extended Dates: December 6, 7 and 8, 2011</p> <p>Facility #: 004091</p> <p>Medicaid Vendor #: 200806840</p> <p>Surveyors: Susan E. Sparks, RN, PHNS, Team Leader</p> <p style="padding-left: 40px;">Bridgett Boston, RN, PHNS, Team Member</p> <p>CJ's Abundant Care is precluded from providing its own training and/or competency evaluation program for a period of two (2) years beginning December 8, 2011 to December 8, 2013 due to being out of compliance with the Conditions of Participation 42 CFR</p>	G0000	<p>On 12/12/2011 Administrator resigned. Alternate DON replaced, Board of Directors appointed new Administrator/Alternate DON: Sonya Welch BSN RN On 12/12/2011 Human Resource Manager was terminated and new employee assigned and oriented to position. 12/12/2011 Clinical Coordinator replaced with experienced Home Health Care RN</p>	

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>484.14: Organization, services, and administration; 484.18 Admission of Patients, Plan of Care, and Medical Supervision; 484.30 Skilled Nursing Services; 484.36 Home Health Aide Services; 484.52: Evaluation of the Agency's Program; and 484.55: Comprehensive Assessment of Patients.</p> <p>Census by Service Type Skilled Patients 63 Home Health Aide Only Patients 25 Personal Service Only Patients 6 Total 94</p> <p>RR w/ HV: 5 RR w/o HV: 6 Total: 11</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 19, 2011</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0109	<p>The patient has the right to participate in the planning of the care.</p> <p>The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p> <p>Based on clinical record review and interview the agency failed to ensure the patient had been involved in the planning of care when the occupational therapist was terminated in 2 of 2 records reviewed of patients being seen by the occupational therapist. (7 and 8 )</p> <p>Findings:</p> <p>1. Clinical record 7, start of care 8/4/11, evidenced a plan of care for the certification period 8/4/11 to 10/2/11 with orders for Occupational Therapy services. The clinical record evidenced a "Discharge Summary/Order" dated 9/8/11 that states, "Effective 9/8/11, discharge Occupational therapy at this time due to termination of Occupational therapy employee. If you wish for patient to be transferred to another agency for Occupational therapy please fax order."</p>	G0109	<p>On 12/12/2011 Administrator resigned. Alternate DON replaced, Board of Directors appointed new Administrator/Alternate DON: Sonya Welch BSN RN On 12/12/2011 Human Resource Manager was terminated and new employee assigned and oriented to position.12/12/2011 Clinical Coordinator replaced with experienced Home Health Care RNAdministrator/DON implemented revised Discharge/Order Summary to ensure patient involved in any changes of the plan of care. Administrator/DON to review every Discharge/Order Summary form to ensure patient involved in any change in their plan of care. The form will include patient signature of choice to remain with agency or choose to transfer to provider that can provide the discharge discipline. Form will then be faxed to physician for order to</p>	01/05/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The clinical record failed to evidence the patient was notified or given the option of choosing another agency.</p> <p>December 8, 2011, at 11 AM, Employee F indicated the clinical record did not evidence the patient had been informed they had the right to choose a different agency in order to receive Occupational Therapy.</p> <p>2. Clinical Record # 8, start of care 8/4/11 evidenced a plan of care for the certification period 8/4/11 through 10/2/11 included an order for occupational therapy to evaluate and treat. The clinical record evidenced that the patient received occupational therapy through 8/26/11. The clinical record evidenced a document titled "Discharge / Summary Order" dated 9/8/11 which states, "D/C [discharge] OT [occupational therapy] effective 9/8/11 due to termination of OT. If you wish for patient to be transferred to another agency for OT, please fax order." The clinical record failed to evidence the patient was notified of the lack of occupational therapist available within the agency and given the option to change agencies or the choice of another agency.</p> <p>On 12/7/11 at 3:45 PM, employee F indicated there was no documentation to evidence the patient was given the</p>		ensure patients participation in care. In-serviced Clinical Coordinator and all nurses on implementation and purpose of form.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0122	<p>opportunity to participate in the plan of care, notified of the termination of the only occupational therapist available with the agency, and the opportunity to exercise the right to transfer to another agency that could provide OT.</p> <p>Based on personnel record review and interview, it was determined the administrator failed to ensure a the employee was oriented by an appropriate person for 3 of 4 records reviewed of professional staff and annual evaluations were completed for 12 of 13 home health aide records reviewed with the potential to affect all the agency's patients (See G 134), failed to ensure the registered nurse and physician coordinated efforts in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients (See G 143), and failed to ensure clinical records evidenced effective communication with the physician in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's</p>	G0122	<p>New orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/NursesReview P&amp;P: 1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesChart Audit with reviewSelf Skills CheckOn site visit with Clinical Coordinator/DON/Alternate</p>	12/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0134	<p>patients (See G 144).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.14: Organization, services, and administration potentially affecting all 73 patients.</p> <p>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.</p>	G0134	<p>DON x2 within 30 daysPseudo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific)Non-professionals:Will be skills checked by contracted qualified RNCompetency testedAnnual evaluations to be performed on site by employees of C.Js Abundant Care Clinical Coordinator/DON/Administrator. Utilizing new process: The employee anniversary date will be tracked in Software and pulled previous month to perform evaluations for upcoming month.100% of Home Health Aides where given an annual performance re-evaluation by Clinical Coordinator/DON 100% of New Personnel orientation will be reviewed by Administrator/Alternate Administrator/DON/Alternate DON to ensure compliance of new orientation process.</p> <p>New orientation</p>	12/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on personnel record review and interview, the administrator failed to ensure a the employee was oriented by an appropriate person for 3 of 4 records reviewed of professional staff (A, C, E, and I) and annual evaluations were completed for 12 of 13 home health aide records reviewed (J, K, L, Q, R, S, T, U, V,W, X, AA) with the potential to affect all the agency's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Personnel record A evidenced the physical therapist orientation being performed by the agency consultant.</li> <li>2. Personnel record C evidenced the physical therapist orientation being performed by human resource personnel.</li> <li>3. Personnel record E evidenced the registered nurse and clinical coordinator orientation being performed by human resource personnel.</li> <li>4. Personnel records J, K, L, Q, R, S, T, U, V, W, X, and AA, all home health aides, evidenced the orientation was conducted at a different agency and faxed to this agency. All orientations were signed by the scheduler.</li> <li>5. December 8, 2011, at 3:30 PM, the</li> </ol>		<p>processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/NursesReview P&amp;P: 1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervison14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesChart Audit with reviewSelf Skills CheckOn site visit with Clinical Coordinator/DON/Alternate DON x2 within 30 daysPsuedo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific)Non-professionals:Will be skills checked by contracted qualified RNCompetency testedAnnual evaluations to be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0143	<p>home health aide scheduler, employee BB, indicated the forms had been faxed from a different agency and were not performed at this agency.</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse and physician coordinated efforts in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was</p>	G0143	<p>performed on site by employees of C.Js Abundant Care Clinical Coordinator/DON/Administrator. Utilizing new process: The employee anniversary date will be tracked in Software and pulled previous month to perform evaluations for upcoming month. 100% of Home Health Aides where given an annual performance re-evaluation by Clinical Coordinator/DON 100% of New Personnel orientation will be reviewed by Administrator/Alternate Administrator/DON/Alternate DON to ensure compliance of new orientation process.</p> <p>To ensure compliance Skilled Nurses in-serviced on following policies and procedures: 1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders/Physician Notification 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care Plan/Documentation 10. Client Admission 11. Oasis Policy 12. Plan of Care 13. Medical Supervision 14. In-services 15. Pressure Ulcer Prevention 16. Pain Management 17. Skilled Nursing Services Physician Verbal Order form changed to include VO date and time on</p>	12/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large</p>		12/9/2011 Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conferences.. Policy revision of Physicians Orders completed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>2. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>I. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>pain and failed to evidence an order for ice or heat."</p> <p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin It [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dressing removed ... small amount green brown drainage to old dressing."</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>P. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>Q. The policy titled "Management /</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>R. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>S. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>T. The record failed to evidence the patient's care was coordinated with the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
G0144	<p>physician at any time.</p> <p>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 review and interview, the agency failed to ensure clinical records evidenced effective communication with the physician in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin</p>	G0144	<p>To ensure compliance SN staff in-serviced on following policies: In-serviced nursing staff on Braden Scale. Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures. Skilled Nursing in-serviced on following Policies and Procedures: 1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders/Physician Notification 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care Plan/Documentation 10. Client</p>	12/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The</p>		<p>Admission11. Oasis Policy12. Plan of Care13. Medical Supervison14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate carewith weekly case conferences. Policy revision of Physicians Orders completed. In-serviced Home Health Aides on Scope of Practice and When to notify supervisor.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>changes and instructions given to clients."</p> <p>2. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
	<p>dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>I. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin It [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>P. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>Q. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>R. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>S. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>T. The record failed to evidence the patient's care was coordinated with the physician at any time.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
G0154	<p>The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.</p> <p>Based on interview and review of agency documents, the agency failed to ensure the professional advisory board met frequently, participated in the agency's annual evaluation, and maintained liaison with other health care providers in 1 of 1 professional advisory board with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. A review of agency documents evidenced a listing, dated 1/28/11, of the members of the advisory board which included a physician, physical therapist, occupational therapist, registered nurse, licensed practical nurse, consumer, and</p>	G0154	<p>Assignment of new Professional Advisory Committe by new Administrator/Alternate DON. Scheduled meeting by Jan. 31st 2012, and meeting anually thereafter (and as needed)to be included in minutes of anticipated date of next meeting. Performance Improvement Committee to meet quarterly with implementation of notification to PAC with copy of minutes. PAC agenda revised with sign in sheet along with the agenda, to address operational/clinical issues. Documentation to be maintained in PAC manual of minutes with sign in sheet, other informational tools utilized for meeting to be filed on site. Administrator/Alternate</p>	01/05/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>owners of the agency.</p> <p>2. A review of the agency documentation failed to evidence a sign in page, meeting minutes, or any other documentation that the professional advisory board had met since January 27, 2011. The documentation failed to evidence that the professional advisory board planned to meet or had met frequently and were involved in the agency's evaluation and maintained liaison with other health providers.</p> <p>3. On December 7, 2011, at 4 PM, employee F indicated that she had not had contact with the Professional Advisory Committee as most of the members of the PAC on the list dated 1/27/11 have left the agency. A new group was formed , but she had not had contact or meetings with the new PAC. There was not any evidence of a written ongoing agency plan or meetings that document the plan for the administrative review as to how the agency was continually evaluating itself and there was no further documentation to evidence.</p>		<p>Administrator will oversee PAC meetings. Professional Advisory Committee has been assigned by Administrator. Members have been notified and accepted date of scheduled meeting. An annual colander developed for scheduled PI meetings. The POA will be presented and reviewed at annual PAC meeting.</p> <p>Administrator/DON will ensure recommendations made by PAC are met by goal date on POA.</p> <p>Revised agenda in place to meet State and Federal requirements. Each committee member shall have signed orientation sheet to PAC. Revised Annual Agency evaluation form in place. Scheduled PAC meeting .POA with every PI will be the written ongoing agency plan as to how agency will continue self evaluation.100% of active patients charts to be audited by Administrator/Clinical Coordinator/DON and any professional staff by 1/5/2012 with Plan of action developed for findings with specific goal dates . Then Assigned audit sheets to appropriate health professionals each quarter with 10% of census ,( mininum 10) active/discharged being audited with review by DON/Alternate DON with Plan of Action developed with goals dates to address and act upon trends.Recert audits to be performed at end of each 60 day</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
G0156	<p>Based on clinical record and policy review and interview, it was determined the agency failed to ensure visits and treatments were provided as ordered on the plan of care and there were orders for all treatments in 6 of 7 clinical records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients (See G 158), failed to ensure the physician was notified of changes in the patient's condition or changes that could affect the patient's condition in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients (See G 164) and failed to ensure verbal orders were obtained in 1 of 2 clinical records reviewed of patients who experienced patient harm with the potential to affect all the patients of the agency (See G 166).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484:18 Acceptance of Patients, Plan of Care, and Medical Supervision potentially affecting all 73 patients.</p>	G0156	<p>episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates..</p> <p>In-serviced SN of following policies and procedures:1. Wound Care2. Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6. Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conferences. Policy revision of Physicians Orders completed. All SN providing care are to recieve copy of Plan of CarePhysicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical</p>	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0158	<p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and policy review and interview, the agency failed to ensure visits and treatments were provided as ordered on the plan of care and there were orders for all treatments in 6 of 7 clinical records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients. (4, 6, 7, 8, 9 and 10)</p> <p>Findings:</p> <p>1. Clinical record 4, SOC 10/27/11, evidenced a plan of care for the certification period 10/27/11 to 12/25/11 with orders for skilled nursing every other week for 9 weeks and home health aide services. The clinical record identified 3 skilled nurse visit during the first week (10/27/11), fourth week (11/17/11), and seventh week (12/8/11).</p> <p>A. The plan of care failed to evidence an order for homemaker services, but the clinical record identified the homemaker</p>	G0158	<p>Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.</p> <p>Assignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON. Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care/service is assigned as evaluating SN has deemed upon SOC, Resumption, Recert and SCIC. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care. Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as warranted. In-service nursing staff on Pain Management, and Braden Scale. Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures. In-service staff on: Skilled Nursing</p>	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>provided services 10/27/11, 11/1/11, 11/10/11, 11/15/11, and 11/21/11.</p> <p>B. On December 5, 2011, at 2:15 PM, Employee F indicated the skilled nursing visits were not as ordered and the homemaker services were not on the plan of care.</p> <p>2. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 10/5/11 to 12/3/11 with orders for skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement. The patient returned home 10/19/11 on Coumadin with home health care orders for "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record does not identify the physician was notified the family wished to discontinue to draw nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of</p>		<p>ServicesPhysician Orders/Physician Notification:Compliance manual implemented to match visit frequency against orders to ensure visits made as per Plan of Care by Clinical Coordinator/Nursing Scheduler</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>care on 11/16/11.</p> <p>3. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the certification period 10/3/11 to 12/1/11 with a physician order for every other week for medication set-up by the skilled nurse. The clinical record identified med set up occurred 10/18/11 and not again until 11/19/11.</p> <p>4. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient was able to get to and from the toilet, able to dress upper body without assistance if clothing was laid out or handed to the patient, and able to bear weight and pivot during the transfer process, but unable to transfer self. An unsigned recertification assessment dated 9/28/11 indicates the patient was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, and requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>A. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>treatment."</p> <p>B. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>C. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note"</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dated 11/19/11 that states, "Reason for visit ... Wd care ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence an order for ice or heat."</p> <p>F. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>G. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY 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 a physician in a timely manner."</p> <p>5. Clinical record 9, SOC 3/17/11, evidenced a plan of care for the certification period 9/13/11 to 11/11/11 with orders for skilled nursing 1 time a day, 7 days a week for 9 weeks for glucometer checks and insulin injection using a sliding scale. Blood sugar results between 141-180 were to receive 1 unit of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>insulin. The clinical record evidenced, on 10/21/11, a blood sugar of 145 with 0 insulin given, 10/25/11 a blood sugar of 151 with 0 insulin given, 11/1/11 a blood sugar of 155 with 0 insulin given, and on 11/4/11 a blood sugar of 161 with 0 insulin given. The clinical record failed to evidence a visit for 11/8/11.</p> <p>6. Clinical record 10, SOC 4/25/10, evidenced a plan of care for the certification period 10/17/11 to 12/15/11 with orders for skilled nursing 1 time a day, 7 day a week, for 9 weeks for glucometer checks and insulin administration. The clinical record failed to evidence the skilled nurse made a visit 10/26/11.</p> <p>7. On December 8, 2011, at 10:30 AM, Employee F indicated the findings in the clinical record were correct.</p> <p>8. A policy dated 1/28/22 titled "Skilled Nursing Services", C-200, states "Skilled nursing services will be provided by a Registered nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders)."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
G0164	<p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the physician was notified of changes in the patient's condition or changes that could affect the patient's condition in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor</p>	G0164	<p>To ensure compliance Skilled Nurses in-serviced on following policies and procedures:</p> <ol style="list-style-type: none"> <li>1. Wound Care</li> <li>2. Ostomy Care</li> <li>3. Documentation</li> <li>4. Case Conference/Coordination of Care</li> <li>5. V/S</li> <li>6. Physician Orders/Physician Notification</li> <li>7. Performance Improvement</li> <li>8. Clinical Record Review</li> <li>9. HHA Supervisory/Care Plan/Documentation</li> <li>10. Client Admission</li> <li>11. Oasis Policy</li> <li>12. Plan of Care</li> <li>13. Medical Supervision</li> <li>14. In-services</li> <li>15. Pressure Ulcer Prevention</li> <li>16. Pain Management</li> <li>17. Skilled Nursing Services</li> </ol> <p>Physician Verbal Order form changed to include VO date and time on 12/9/2011 Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care. with weekly case conference. Policy revision of Physicians Orders completed. All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. Original assessments will be filed</p>	12/28/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no</p>		<p>in patients chart. Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax.</p> <p>Clinical Coordinator/Administrator/DON/Alternate DON to review log book weekly to ensure compliance. Assignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON. Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care is assigned as evaluating SN has deemed upon SOC, Resumption, Recert and SCIC. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care. Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as warranted. In-serviced nursing staff on Pain Management, and Braden Scale. Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>2. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient</p>		<p>measures.:Compliance manual implemented to match visit frequency against orders to ensure visits made as per Plan of Care by Clinical Coordinator/Nursing Scheduler</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin lt [left] foot location - left foot - duration -</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>P. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>Q. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>R. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0166	<p>reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>S. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>T. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>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. Based on clinical record and policy review and interview, the agency failed to</p>	G0166	To ensure compliance Skilled Nurses in-serviced on following	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>ensure verbal orders were obtained in 1 of 2 clinical records reviewed of patients who experienced patient harm with the potential to affect all the patients of the agency. (#6)</p> <p>Findings:</p> <p>1. Clinical record 6, start of care 10/5/11, evidenced a plan of care for the certification period 10/5/11 to 12/3/11 with orders for skilled nursing, home health aide and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement. The patient returned home 10/19/11 on Coumadin with home health care orders for "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record does not evidence the physician was notified the family wished to discontinue to draw nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p>		<p>policies and procedures:1. Wound Care2. Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6. Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conference. Policy revision of Physicians Orders completed. Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>A. "Centricity Clinical Information" dated 11/12/2011 indicated the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardic."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>2. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable State and federal law and organization policy. All verbal orders</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
G0168	<p>must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>Based on clinical record and policy review and interview, it was determined the agency failed to ensure the skilled nurse provided visits and treatments as ordered on the plan of care and there were orders for all treatments in 6 of 7 clinical records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients (See G 170), failed to ensure the registered nurse did the initial evaluation in 3 of 3 clinical</p>	G0168	<p>Skilled Nurses in-serviced on following policies and procedures:1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15.</p>	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	records reviewed of patients with skilled services since the recertification survey 7/11 with the potential to affect all new patients of the agency (See G 171), failed to ensure the registered nurse reevaluated the patient's needs after a significant change condition in 1 of 1 record reviewed of patients with a significant change in condition (#8) and completed a recertification comprehensive assessment in 5 of 5 clinical records reviewed of patients receiving services over 60 days with the potential to affect all the agency's patients who receive services longer than 60 days (See G 172), failed to ensure the registered nurse initiated revisions in to the plan of care in 1 of 2 records reviewed of patients who experienced harm with the potential to affect all the agency's patients (See G 173), failed to ensure the registered nurse used her nursing knowledge and skill to prevent patient harm in 1 of 2 records reviewed of patients who experience harm (See G 174), failed to ensure the registered nurse initiated preventative nursing procedures to prevent patient harm in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients (See G 175), and failed to ensure the registered nurse coordinated services with the physician to prevent patient harm in 2 of 2 clinical records reviewed of patients		Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conferences. Policy revision of Physicians Orders completed. Original OASIS/Comprehensive assessments will be turned into Clinical Coordinator/DON/Alternate DON for review. After data entry and locking assessment, Data entry employee will file assessment into patient chart.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>whose care resulted in patient harm with the potential to affect all the agency's patients (See 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.30 Skilled Nurse Services potentiality affecting all 73 patients of the agency.</p>				
G0170	<p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the skilled nurse provided visits and treatments as ordered on the plan of care and there were orders for all treatments in 6 of 7 clinical records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients. (4, 6, 7, 8, 9 and 10)</p>	G0170	<p>Assignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON. Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care is assigned as evaluating SN has deemed upon SOC, and RECERT. Plan of</p>	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
	<p>Findings:</p> <p>1. Clinical record 4, SOC 10/27/11, evidenced a plan of care for the certification period 10/27/11 to 12/25/11 with orders for skilled nursing every other week for 9 weeks and home health aide services. The clinical record identified 3 skilled nurse visit during the first week (10/27/11), fourth week (11/17/11), and seventh week (12/8/11).</p> <p>On December 5, 2011, at 2:15 PM, Employee F indicated the skilled nursing visits were not as ordered on the plan of care.</p> <p>2. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 10/5/11 to 12/3/11 with orders for skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement. The patient returned home 10/19/11 on Coumadin with home health care orders for "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time</p>		<p>Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care.Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as warranted.In-serviced nursing staff on following Policies and Procedures 1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing Services:and Braden Scale.Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures.New orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/NursesReview</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record does not identify the physician was notified the family wished to discontinue to draw nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>3. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the certification period 10/3/11 to 12/1/11 with a physician order for every other week for medication set-up by the skilled nurse. The clinical record identified med set up occurred 10/18/11 and not again until 11/19/11.</p> <p>4. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient was able to get to and from the toilet, able to dress upper body without assistance if clothing was laid out or handed to the patient, and able to bear weight and pivot during the transfer process, but unable to transfer self. An unsigned recertification assessment dated 9/28/11 indicates the patient was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside</p>		<p>P&amp;P: 1. Wound Care2. Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6. Physician Orders7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesChart Audit with reviewSelf Skills CheckOn site visit with Clinical Coordinator x2 within 30 days by Clinical Coordinator/DON/Alternate DONPseudo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific)All SN providing care are to receive copy of Plan of Care</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>commode, and requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>A. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment."</p> <p>B. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>C. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ...</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence an order for ice or heat."</p> <p>F. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>G. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY 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 a physician in a timely manner."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>5. Clinical record 9, SOC 3/17/11, evidenced a plan of care for the certification period 9/13/11 to 11/11/11 with orders for skilled nursing 1 time a day, 7 days a week for 9 weeks for glucometer checks and insulin injection using a sliding scale. Blood sugar results between 141-180 were to receive 1 unit of insulin. The clinical record evidenced, on 10/21/11, a blood sugar of 145 with 0 insulin given, 10/25/11 a blood sugar of 151 with 0 insulin given, 11/1/11 a blood sugar of 155 with 0 insulin given, and on 11/4/11 a blood sugar of 161 with 0 insulin given. The clinical record failed to evidence a visit for 11/8/11.</p> <p>6. Clinical record 10, SOC 4/25/10, evidenced a plan of care for the certification period 10/17/11 to 12/15/11 with orders for skilled nursing 1 time a day, 7 day a week, for 9 weeks for glucometer checks and insulin administration. The clinical record failed to evidence the skilled nurse made a visit 10/26/11.</p> <p>7. On December 8, 2011, at 10:30 AM, Employee F indicated the findings in the clinical record were correct.</p> <p>8. A policy dated 1/28/22 titled "Skilled Nursing Services", C-200, states "Skilled</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0171	<p>nursing services will be provided by a Registered nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders)."</p> <p>The registered nurse makes the initial evaluation visit.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse did the initial evaluation in 3 of 3 clinical records reviewed of patients with skilled services since the recertification survey 7/11 with the potential to affect all new patients of the agency. (4, 6, and 7)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record 4, start of care (SOC) 10/27/11, evidenced a plan of care for the certification period 10/27/11 to 12/25/11 with orders for skilled nursing and home health aide services. The clinical record failed to evidence an initial assessment by the registered nurse.</li> <li>2. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 10/5/11-12/3/11 with</li> </ol>	G0171	All original assessments will be turned into Clinical Coordinator/DON/Alternate DON for review and Data entry. Original assessments will be filed in patients chart after data entry and locking by Data entry employee. In-serviced internal staff for record retention of documents.	12/12/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
G0172	<p>orders for skilled nursing, home health aide, and physical therapy services. The clinical record failed to evidence an initial assessment by the registered nurse.</p> <p>3. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the certification period 8/4/11 to 10/2/11 with orders for skilled nursing, home health aide, occupational therapy, physical therapy, attendant care and homemaker services. The clinical record failed to evidence a initial assessment by the registered nurse.</p> <p>4. December 5, 2011, at 12 PM, the Clinical Coordinator Employee E indicated all assessment forms had been shredded and the only forms available were computer generated Oasis forms.</p> <p>The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse reevaluated the patient's needs after a significant change condition in 1 of 1 record reviewed of patients with a significant change in condition (#8) and completed a recertification comprehensive assessment in 5 of 5 clinical records reviewed of patients receiving services over 60 days</p>	G0172	<p>100% of Nursing staff in-serviced on recertification, reassessment for 60 day episode, post hospital, or significant change in condition. Clinical Coordinator/DON/Alternate DON will review 100% of assessments of professional documentation to ensure compliance Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing</p>	01/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>with the potential to affect all the agency's patients who receive services longer than 60 days. (#6, 7, 8, 9 and 10)</p> <p>Findings:</p> <p>1. Clinical Record # 8, start of care 8/4/11, evidenced a plan of care for the certification period 10/3/11 through 12/1/11 with orders for the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The clinical record evidenced a skilled nurse visit note dated 10/31/11 at 4 PM, written by employee I, that states, "Client seized for about 5 minutes, ... medics alerted, ... transferred per ambulance to hospital." The clinical record failed to evidence a visit note or a missed visit notification for 11/1/11. The clinical record evidenced a skilled nurse visit note dated 11/2/11 written by employee I which indicates the patient was home on 11/2/11. The clinical record failed to evidence an other follow up assessment was completed when the patient returned home from the seizure episode.</p> <p>On December 7, 2011, at 4:05 PM, employee F indicated there was not a reassessment of the patient upon return from the seizure episode nor was there sufficient documentation in the clinical record to know when the patient returned</p>		<p>notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>home from the hospital, the condition of the patient upon return, or what treatment the patient received.</p> <p>2. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 12/4/11 to 2/2/12 with orders for skilled nursing, home health aide, and physical therapy. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment.</p> <p>3. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the certification period 10/3/11 to 12/1/11 with orders for skilled nursing, home health aide, physical therapy, attendant care, and homemaker. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment.</p> <p>4. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned start of care assessment dated 8/4/11. The recertification assessment dated 9/28/11 was also unsigned.</p> <p>5. Clinical record 9, SOC 3/17/11, evidenced a plan of care for the certification periods 7/15/11 to 9/12/11, 9/13/11 to 11/11/11, and 11/12/11 to 1/10/12. The clinical record failed to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>evidence the registered nurse had completed a recertification comprehensive assessment for the certification periods identified.</p> <p>6. Clinical record 10, SOC 4/25/10, evidenced a plan of care for the certification periods 8/18/11 to 10/16/11 and 10/17/11 to 12/15/11. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment for the certification periods identified.</p> <p>7. December 5, 2011, at 12 PM, the Clinical Coordinator, Employee E, indicated all assessment forms had been shredded and the only forms available were computer generated Oasis forms.</p> <p>8. A policy approved 1/28/11 "Client Reassessment/Update of Comprehensive Assessment" C-155 states, "The Comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status. ... Reassessments must be done at least: 1. Every second calendar month beginning with start of care (within last 5 days of the episode, including day 60), 2. Within 48 hours of (or knowledge of) client return home from hospital admission of more than 24 hours for any reason other than</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0173	<p>diagnostic testing or other changes representing a SCIC (Significant Change in Condition). 3. Within 48 hours of (or knowledge of) discharge or transfer."</p> <p>The registered nurse initiates the plan of care and necessary revisions. Based on clinical record and policy review, observation, and interview, the agency failed to ensure the registered nurse initiated revisions in to the plan of care in 1 of 2 records reviewed of patients who experienced harm with the potential to affect all the agency's patients. (#8)</p> <p>Findings:</p> <p>1. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly,</p>	G0173	To ensure compliance:Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON.Recert audits to be	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with</p>		<p>performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON and reviewed by Administrator/Alternate Administrator. In-serviced SN of following policies and procedures: 1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders/Physician Notification 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care Plan/Documentation 10. Client Admission 11. Oasis Policy 12. Plan of Care 13. Medical Supervision 14. In-services 15. Pressure Ulcer Prevention 16. Pain Management 17. Skilled Nursing Services Physician Verbal Order form changed to include VO date and time on 12/9/2011 Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care. To ensure compliance by weekly case conference. Policy revision of Physicians Orders completed. All SN providing care are to receive copy of Plan of Care Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and</p>		<p>phone notification of returned fax. Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance. All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. .Original assessments will be filed in patients chart after data entry and locking by Data entry employee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound." The record failed to evidence a revision to the plan of care to address the bedbound status.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>/ heat therapy for left foot." The clinical record failed to evidence a revision to the plan of care to address the patient's increased pain and an order for ice or heat.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin It [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat.</p> <p>I. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence a revision to the plan of care to address the patient's increased lack of a caregiver on a regular basis.</p> <p>J. On December 7, 2011, at 10:20 AM, employee I indicated that she completed the reassessment for the patient</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p># 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>2. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>3. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0174	<p>4. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>6. The policy titled "Client Reassessment / Update of the Comprehensive Assessment" states, The comprehensive assessment will be updated and revised as often as the clients condition warrants due to a major decline ... Within 48 hours of or knowledge of client return from a hospital admission of more than 24 hours, ... or other changes representing a SCIC (significant change in condition). PURPOSE To identify decline or improvement in health status, modify the plan of care and document changes that may affect care and reimbursement."</p> <p>The registered nurse furnishes those services requiring substantial and specialized nursing skill. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse used her nursing knowledge and skill to prevent</p>	G0174	To ensure compliance Skilled Nurses in-serviced on following policies and procedures:1. Wound Care2.Ostomy Care3. Documentation4. Case	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>patient harm in 1 of 2 records reviewed of patients who experience harm. (#6).</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient</p>		<p>Conference/Coordination of Care5. V/S6. Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conferences. Policy revision of Physicians Orders completed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>2. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0175	documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."  The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.  Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse initiated preventative nursing procedures to prevent patient harm in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)	G0175	To ensure compliance:Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival</p>		<p>months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON and reviewed by Administrator/Alternate Administrator In-serviced SN of following policies and procedures: 1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders/Physician Notification 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care Plan/Documentation 10. Client Admission 11. Oasis Policy 12. Plan of Care 13. Medical Supervision 14. In-services 15. Pressure Ulcer Prevention 16. Pain Management 17. Skilled Nursing Services Physician Verbal Order form changed to include VO date and time on 12/9/2011 Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the</p>		<p>Physician Orders and Notifications and coordinate care with weekly case conference. To ensure compliance by onsite weekly case conference.</p> <p>Policy revision of Physicians Orders completed. All SN providing care are to recieve copy of Plan of CarePhysicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax.</p> <p>Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.All original assessments will be turned into Clinical Coordinator/DON/Alternate DON for review and Data entered. Original assessments will be filed in patients chart once data entried and locked by Data entry employee.New orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/NursesReview P&amp;P: 1. Wound Care2. Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent to the physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>3. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped</p>		<p>Plan of Care 13. Medical Supervision 14. In-services 15. Pressure Ulcer Prevention 16. Pain Management 17. Skilled Nursing Services Chart Audit with review Self Skills Check On site visit with Clinical Coordinator x2 within 30 days by Clinical Coordinator/DON/Alternate DON suedo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific) Non-professionals: Will be skills checked by contracted qualified RN Competency tested Annual evaluations to be performed on site by employees of CJs Abundant Care Clinical Coordinator/DON/Administrator on employee anniversary date as tracked in Software and pulled previous month to perform evaluations for upcoming month. 100% of Home Health Aides where given an annual performance re-evaluation by Clinical Coordinator/DON</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin lt [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>caregiver in the home between the visits from the home health agency.</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>P. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>Q. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>R. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>S. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>T. Agency policy #C-635, not dated,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0176	<p>titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>U. The record failed to evidence the patient's care was coordinated with the physician at any time.</p> <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.</p>	G0176	<p>To ensure compliance SN staff in-serviced on following policies:In-serviced nursing staff on Braden Scale.Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures.Skilled Nursing in-serviced on following Policies and Procedures:1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client</p>	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse coordinated services with the physician to prevent patient harm in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical</p>		<p>Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care. To ensure compliance by onsite weekly case conference. Policy revision of Physicians Orders completed. SN upon SOC, Recert, Resumption and SCIC will verify on assessment the primary caregiver for patient.In-serviced Home Health Aides on Scope of Practice and When to notify supervisor.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>3. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin lt [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>P. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>Q. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>R. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>S. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>T. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>U. The record failed to evidence the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0202	<p>patient's care was coordinated with the physician at any time.</p> <p>Based on clinical record and policy review and interview, it was determined the agency failed to ensure the registered nurse updated the home health aide assignment as the patient's needs changed and mobility decreased for 1 of 9 clinical records reviewed of patients receiving home health aide services (See G 224), failed to ensure the home health aides furnished care only as identified on the aide care plan in 5 of 9 records reviewed of patients with orders for home health aide services with the potential to affect all the patients of the agency (G 225), failed to ensure the registered nurse supervised the aide every two weeks in 5 of 5 clinical records reviewed of patients who received home health aide and skilled nurse services and the agency policy was congruent with federal requirements with the potential to affect all the patients of the agency receiving home health aide services (See G 229), and failed to ensure the aide was observed giving care every 30 days as required by</p>	G0202	<p>To ensure compliance, purchased new Home Health Aide care plans and Home Health Aide notes that coorelate with care plan. Inserviced 100% of Nurses and Home Health Aides on new documents and proper documentation on forms to match Plan of Care. Inserviced 100% of nurses on 12/22/2011 on policy/Regulation of Home Health Aide supervisory and Home Health needing to be observed providing personal care every 30 days. Aide Supervision form revised to ensure aide present with aide/patient signing form and with observation of personal care being performed every 30 days. Nursing Scheduler will monitor schedules with supervisory visits scheduled as well one week prior to next month. Nursing Scheduler will confirm with nurse. Will be monitored weekly by Clinical Coordniator with compliance manual of skilled nurse visits and supervision. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes</p>	12/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0224	<p>agency policy in 3 of 4 clinical records reviewed of patients with home health aide only services with the potential to affect all the patients of the agency receiving home health aide services (See G 230).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.36 Home Health Aide Services potentially affecting all 73 patients of the agency.</p> <p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse updated the</p>	G0224	<p>will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON.</p> <p>To ensure compliance Home Health Aides in-serviced on scope of practice of the Home Health Aide and when to report to</p>	12/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>home health aide assignment as the patient's needs changed and mobility decreased for 1 of 9 clinical records reviewed of patients receiving home health aide services. (# 8)</p> <p>Findings include:</p> <p>1. Clinical Record # 8, start of care 8/4/11, evidenced a plan of care for the certification period 10/3/11 through 12/1/11 that identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9</p>		<p>supervisor. Skilled Nursing in-serviced on Home Health Aide supervisory, Care Plan, and documentation. Skilled Nurse to update Home Health Aide care plan as reported by changes by Home Health Aide, or upon supervisory visits, with SCIC, reassessment, and recert of patient. Clinical Coordinator/Don/Administrator to perform clinical record reviews at recert and quarterly. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>weeks for assistance with homemaking activities."</p> <p>A. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed with a cast on the right ankle and foot and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room and informed that the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago" and then indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient had not been routinely out of bed except for a doctors appointment. The surveyor</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>observed the patient to have 2 open areas on the left buttock. Employee J indicated the patient had been developing open areas since the first foot was fractured. Employee J indicated the treatment and applied to the patient's open skin areas on the left buttock medication from the tube labeled "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>B. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F, and the record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>C. The "Home Health Aide Assignment Sheet /Plan of Care" dated 11/29/11 had a column titled "Activities" and, under the word ambulate, the patient's mode of mobility with a walker</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>was part of the aide's assignment.</p> <p>D. On 12/6/11 at 12 PM, employee J indicated the patient was not ambulatory as both feet were broken. The assignment sheet failed to evidence it had been updated to reflect this change.</p> <p>2. The policy titled "Home Health Aide Services" states, Services will be provided to appropriate clients ... under the direct supervision of an agency registered nurse / therapist in accordance with a medically approved plan of care. ... The aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising nurse. ... Delegated nursing tasks performed by home health aides must be properly delegated and documented according to specific state / federal and agency policies."</p> <p>3. The policy titled "Home Health Aide: Assignment states, "To provide direction and supervision of care provided by the home health aides. ... Any change in the assignment must be approved by the professional managing the client's care. ... All changes in the assignment will be communicated to the Home Health Aide and will be documented on a new Care Plan."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0225	<p>The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record and policy review, observation, and interview, the agency failed to ensure the home health aides furnished care only as identified on the aide care plan in 5 of 9 records reviewed of patients with orders for home health aide services with the potential to affect all the patients of the agency. (1, 2, 7, 9, and 10)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 8/22/11, evidenced a plan of care for the certification period 10/21/11 to 12/19/11 with orders for home health aide (HHA) services. The "Aide Care Plan" dated 10/18/11 failed to evidence the aide was to "comb hair/brush hair, shampoo hair, mouth care/dentures, wheelchair/cane and snack." The clinical record evidenced the aide performed on 10/6/11 shampoo hair, dentures, walker/cane; on 10/7/11 dentures, walker / cane, snack, on 10/10/11, 10/14/11, 10/17/11, 10/24/11, 10/31/11, 11/4/11, 11/7/11, and 11/11/11 shampoo hair, comb hair/brush hair / dentures, wheelchair / cane, snack; on</p>	G0225	<p>To ensure compliance, purchased new Home Health Aide care plans and Home Health Aide notes that coorelate with care plan. Inserviced 100% of Nurses and Home Health Aides on new documents and proper documentation on forms to match Plan of Care. Inserviced 100% of nurses on 12/22/2011 on policy/Regulation of Home Health Aide supervisory and Home Health needing to be observed providing personal care every 30 days. Aide Supervision form revised to ensure aide present with aide/patient signing form and with observation of personal care being performed every 30 days. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON.</p>	12/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>10/11/11 - 10/13/11, 11/8/11-11/10/11 comb hair /brush hair, dentures, wheelchair / cane / snack; and on 10/18/11-10/21/11, 10/25/11-10/28/11, 11/1/11-11/3/11 comb hair / brush hair, dentures, wheelchair / cane.</p> <p>2. Clinical record 2, SOC 6/2/11, evidenced a plan of care for 9/30/11 to 11/28/11 with orders for HHA services. The "Aide Care Plan" dated 9/27/11 failed to evidence a physician order for "complete bed bath, shampoo hair shave, cath care, lotion skin, and snack." The clinical record evidenced on 9/26/11 - 9/29/11, 10/10/11 - 10/13/11, 10/17/11 - 10/18/11, 10/20/11-10/21/11, 10/25/11-10/26/11, 10/28/11-10/29/11, 10/31/11-11/3/11, 11/7/11-11/10/11, 11/14/11-11/11/17/11, and 11/21/11-11/24/11 was performed a complete bed bath, shave, lotion skin, and snack; 9/30/11 shave, lotion skin, and snack; 10/14/11, 10/27/11, 11/4/11, 11/11/11, 11/18/11, and 11/25/11 shampoo hair, shave, lotion skin, and snack; 10/24/11 cath care.</p> <p>3. Clinical record 9, SOC 3/17/11, evidence a plan of care for 9/13/11 to 11/11/11 with orders for HHA services. The "Aide Care Plan" dated 9/8/11 failed to evidence a physician order for "Complete / Partial Bed Bath." The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>clinical record evidenced a bed bath was given on 9/7/11, 9/16/11, 9/28/11, 10/9/11, 10/12/11, and 11/3/11.</p> <p>10. Clinical record 10, SOC 4/25/10, evidenced a plan of care for 10/17/11 to 12/15/11 with orders for HHA services. The "Aide Care Plan" dated 10/13/11 failed to evidence a physician order for "Nutrition Prepare Meal." The clinical record evidenced the aide prepared meals on 10/18/11 - 10/21/11, 10/24/11 - 10/28/11, 10/31/11 - 11/4/11, 11/7/11 - 11/11/11, 11/14/11 - 11/18/11, and 11/21/11 - 11/25/11.</p> <p>4. A policy dated 1/28/11 titled "Home Health Aide Care Plan", C-751, states, "A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide shall be developed by a Registered Nurse or Therapist. All home health aide staff will follow the identified plan. The Care Plan will be available to all persons involved in client care, including contracted providers."</p> <p>5. On December 5, 2011, at 2:15 PM, Employee F indicated the aides were not giving care according to the Aide's Care Plan.</p> <p>6. During a home visit on 12/6/11 at 11 AM, employee CC was observed to apply neosporin to the multiple skin tears on the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>patient's bilateral upper arms. The employee indicated that upon arrival to the patient's home on 12/5/11, she found written instructions from an unidentified source that instructed her to wash and dry the patient's skin tears and then to apply the neosporin ointment to the wounds. Employee CC indicated she followed the instructions on 12/5/11. The patient indicated that the skin tears occurred during a fall in the garage of the house on Saturday, 12/3/11.</p> <p>Clinical record # 7 evidenced a plan of care for the certification period 10/3/11 through 12/1/11 that failed to evidence a physician order to treat the patient's skin tears and failed to evidence the aide notified the nurse regarding the patient's fall and injuries.</p> <p>7. The policy titled "Home Health Aide Services" states, Services will be provided to appropriate clients ... under the direct supervision of an agency registered nurse / therapist in accordance with a medically approved plan of care. ... The aide will follow the care plan and will not initiate new services ... without contacting the supervising nurse. ... Delegated nursing tasks performed by home health aides must be properly delegated and documented according to specific state / federal and agency policies."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0229	<p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on clinical record and policy review and interview the agency failed to ensure the registered nurse supervised the aide every two weeks in 5 of 5 clinical records reviewed of patients who received home health aide and skilled nurse services and the agency policy was congruent with federal requirements with the potential to affect all the patients of the agency receiving home health aide services. (4, 7, 8, 9 and 10)</p> <p>Findings:</p> <p>1. Clinical record 4, start of care (SOC) 10/27/11, evidenced a plan of care with orders for skilled nursing and home health aide services for the certification period 10/27/11 to 12/25/11. The clinical record failed to evidence a supervisory visits was made for the home health aide until the 7th week.</p>	G0229	<p>Inserviced 100% of nurses on 12/22/2011 on policy/Regulation of Home Health Aide supervisory and Home Health needing to be observed providing personal care every 30 days. Aide Supervision form revised to ensure aide present with aide/patient signing form and with observation of personal care being performed every 30 days. If skilled services are provided the Home Health Aide Supervisory will be performed every 2 weeks, with Home Health Aide present or not present. With Home Health Aide present every 30 days for observation of personal care by supervising nurse. Nursing Scheduler will monitor schedules with supervisory visits scheduled as well one week prior to next month. Nursing Scheduler will confirm with nurse. Will be monitored weekly by Clinical Coordiniator with compliance manual of skilled nurse visits and</p>	12/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. Clinical record 7, SOC 8/4/11, evidenced a plan of care with orders for skilled nursing and home health aide services for the certification period 10/3/11 to 12/1/11. The clinical record evidenced a gap between supervisory visits of 21 days between 11/1/11 to 11/22/11.</p> <p>3. Clinical Record # 8, start of care 8/4/11, evidenced a plan of care for the certification period 10/3/11 through 12/1/11 with orders for the skilled nurse (SN) to visit once a day, seven days a week for 9 weeks. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living]." The clinical record evidenced the registered nurse supervised the aide on 11/14/11 and 11/29/11, a period of 15 days.</p> <p>4. Clinical record 9, SOC 3/17/11, evidences a plan of care for the certification period 9/13/11 to 11/11/11 with orders for skilled nursing, home health aide, and homemaker services. A supervisory visit was not made until the</p>		<p>supervison. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>eighth week of the certification period on 10/31/11.</p> <p>5. Clinical record 10, SOC 4/25/10, evidenced a plan of care for the certification period 10/17/11 to 12/15/11 with orders for skilled nursing, home health aide, homemaking, and attendant care services. A supervisory visit was made 10/5/11 for the previous certification period and another supervisory visit was not made until 26 days later on 10/31/11.</p> <p>6. On December 9, 2011, at 11:00 AM, Employee F indicated the supervisory visits had not been made as required.</p> <p>7. A policy approved, 1/28/11, "Home Health Aide Supervision" C-340 states, "3. Supervisory visits of Home Health Aides shall be according to the following frequency: a. When skilled services are being provided to a client, a Registered Nurse/therapist must make a supervisory visit to the client's residence at last every 30 days (either when the Home Health Aide is absent) to assess relationships and determine whether goals are being met."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0230	<p>If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 62 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care. Based on clinical record and policy review and interview, the agency failed to ensure the aide was observed giving care every 30 days as required by agency policy in 3 of 4 clinical records reviewed of patients with home health aide only services with the potential to affect all the patients of the agency receiving home health aide services. (1, 2 and 3)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 8/22/11, evidenced a plan of care for home health aide (HHA) 1 - 4 hours a day, 3 - 6 times a week for 9 weeks for the certification period 10/21/11 to 12/19/11.</p>	G0230	To ensure compliance, purchased new Home Health Aide care plans and Home Health Aide notes that coorelate with care plan. Inserved 100% of Nurses and Home Health Aides on new documents and proper documentation on forms to match Plan of Care. Inserved 100% of nurses on 12/22/2011 on policy/Regulation of Home Health Aide supervisory and Home Health needing to be observed providing personal care every 30 days. Aide Supervision form revised to ensure aide present with aide/patient signing form and with observation of personal care being performed every 30 days. Nursing Scheduler will monitor schedules with	12/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The clinical record failed to evidence a supervisory visit while the aide was providing care.</p> <p>2. Clinical record 2, SOC 6/2/11, evidenced a plan of care for HHA 2-3 hours a day, 4-5 days a week, x 9 weeks for the certification period 9/30/11 to 11/28/11. The clinical record failed to evidence a supervisory visit while the aide was providing care.</p> <p>3. Clinical record 3, SOC 5/24/11, evidenced a plan of care for HHA 1-2 hours a day, 2-3 times a week x 9 weeks for the certification period 9/21/11 to 11/19/11. The clinical record failed to evidence a supervisory visit while the aide was providing.</p> <p>4. December 9, 2011, at 11:30 AM, Employee indicated the aides were not performing care during the supervisory visits.</p> <p>5. A policy approved 1/28/11 titled "Home Health Aide Supervision", C-340, states, "3. Supervisory visits of Home Health Aides shall be according to the following frequency: b. Home Health Aide services only: When Home Health Aide services are being furnished to a client, who does not require the skilled service of a nurse or therapist, a</p>		<p>supervisory visits scheduled as well one week prior to next month. Nursing Scheduler will confirm with nurse. Will be monitored weekly by Clinical Coordniator with compliance manual of skilled nurse visits and supervison. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
G0242	Registered Nurse must make a supervisory visit to the client's residence at least once every 30 days. Each supervisory visit must occur when the Home Health Aide is providing client care."  Based on policy and administrative document review and interview, it was determined the agency failed to ensure a plan was in place for the ongoing annual evaluation of the agency's program for 1 of 1 agency with the potential to affect all the agency's 73 patients (See G 244), failed to ensure a plan was in place for the ongoing annual evaluation that assesses the extent to which the agency's program is appropriate, adequate, effective and efficient for 1 of 1 agency with the potential to affect all the agency's 73 patients (See G 245), failed to ensure a plan was in place for the ongoing annual evaluation that identified issues that could be reported and acted upon by those responsible for the operation of the agency for 1 of 1 agency with the	G0242	Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate	01/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>potential to affect all the agency's 73 patients (See G 246), failed to ensure a plan was in place for the ongoing annual evaluation that assessed the policies and administrative practices of the agency to determine the extent to which the promote patient care that is appropriate, adequate, effective and efficient for 1 of 1 agency with the potential to affect all the agency's 73 patients (See G 248) failed to ensure a plan was in place for collection of pertinent data to assist in evaluation for 1 of 1 agency with the potential to affect all the agency's 73 patients (See G 249), failed to ensure quarterly chart audits were conducted as part of the evaluation process for 1 of 1 agency with the potential to affect all the agency's 73 patients (See G 250), and failed to ensure a continuing review of clinical records was completed to determine adequacy of the plan of care and appropriateness of continuation of care for each 60 day period a patient receives services for 1 of 1 agency with the potential to affect all the agency's 73 patients (See G 251).</p> <p>The cumulative effect of these systemic problems has resulted in the agency being out of compliance with the Condition of Participation 484.52: Evaluation of the Agency's Program resulting in the potential to affect all the patients of the agency.</p>		DON.Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0244	<p>The evaluation consists of an overall policy and administrative review and a clinical record review.</p> <p>Based on policy and administrative document review and interview, the agency failed to ensure a plan was in place for the ongoing evaluation of the agency's program for 1 of 1 agency with the potential to effect all 73 patients served by the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Administrative documents failed to evidence the agency prioritized the resolution of any identified problems and addressed how monitoring of the effectiveness of the program would be accomplished and documented.</li> <li>The agency policy titled "Clinical Record Review" approval date 1/28/11 states, "A clinical record review will be conducted to determine the extent to which CJ ' s Abundant Care staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by representatives of appropriate health care disciplines. ... Purpose: To evaluate</li> </ol>	G0244	<p>Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON. 100% of active patients charts to be audited by Administrator/Clinical Coordinator/DON and any professional staff of last 2</p>	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>appropriate admission and discharge. To evaluate the appropriateness, adequacy and effectiveness of services. To identify over - under utilization of services. To identify gaps in agency service, and need for in-service education, staffing, consulting services, and agency policies. To ensure records reflect care and / or service provided, the client ' s current condition, and the client ' s progress towards goals and condition at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plan s of care. To evaluate adverse outcome reports and identify documentation limitations or the need for focused plan to improve client outcomes through targeted interventions. Special Instructions: The Clinical Record Review Committee is a subcommittee of the Professional Advisory Committee. ... The responsibility for the review program is primarily assigned to the Director of Nursing / designee. The committee is responsible for client care evaluation. ... The committee shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. ... The committee shall make recommendations about specific client documentation issues to the administrator to review. ... The</p>		<p>certification periods by 1/5/2012 with Plan of action developed for findings with specific goal dates . Then Assigned audit sheets to appropriate health professionals each quarter with 10% of census ,( mininum 10) active/discharged being audited with review by DON/Alternate DON with Plan of Action developed with goals dates to address and act upon trends.Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Committee shall routinely examine the findings of the previous reviews to determine focus and assure quality client care." The agency documents failed to evidence the agency had completed quarterly chart audits per agency policy since June 17, 2011.</p> <p>3. The policy titled "Performance Improvement" states, "Purpose: To improve client and agency outcomes through a coordinated collaborative approach to assessing and improving organizational structure. ... To identify deviations from CJ's and professional standards and pursue improvement opportunities by assessment, planning and evaluation. ... To reduce factors that contribute to unanticipated adverse events and / or outcomes. ... Activities for performance improvement will be the responsibility of the Administrator. Program will reflect participation by all services and all levels of staff. Data will be collected to allow the agency to monitor its performance. ... Data will be systematically collected to measure process and outcome. ... Intensive assessment will be completed when undesirable patterns or trends in performance is detected or important sentinel events are identified. The plan will target the performance of existing processes and outcomes and identify /</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>design new processes based on priorities, standards, and resources."</p> <p>4. On December 7, 2011, at 1:45 PM, employee F indicated the extent of the clinical record review and quality assurance and improvement program available was presented for review to the surveyors and the physical therapist who was to have developed a fall prevention program had left the agency and the agency management had yet to develop and implement a program.</p> <p>5. Eleven documents titled "Audit Tool" were presented as evidence of the agency's clinical record review ending with the 3rd quarter in September of 2011. Each of the 11 Audit Tools contained a patient's name and a list of items the auditor was to determine if the record had met compliance. Only 2 of the Audit Tools completed included the name of the auditor; 8 of the Audit Tools failed to identify the Recertification period in review; 5 of the Audit Tools failed to identify the date the audit was completed.</p> <p>A. One of the undated "Audit Tools" states, "485 (5/21 to 7/19/11) had diagnosis of pressure ulcer heel. She doesn't have area on heel." In another area of the same audit states, "No skilled nurse ordered."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>B. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 2nd indicates that a total of 16 clinical records were reviewed. The agency failed to evidence the 16 clinical record reviews that were completed.</p> <p>C. The document titled "Clinical Record Review Results" dated as 2011 Quarter 2nd indicates the agency's census was 112 for the quarter and stated, "Items not filled out in 7 charts, patient response to teaching, coordination of care, discharge planning, aide supervision, vital signs, no orders for the Recertification. Other findings: frequency off, discharge summary not done, 60 day summary not done, wrong diagnosis, diagnosis does not match the 485, patient signatures and orders not back."</p> <p>D. The document titled "PI Minutes" states, "2 nd Quarter 2011 ... 7/14/11 ... Infection Report 26 patient infections ... Trends - 16 UTI (urinary tract infections) Action - In service aides on proper peri / cath care due to 11 /16 have anchored cathes. ... Occurrence Reports: 12 Patient reports ... 10 falls with 5 witnessed and 2 resulted in an ER visit Trends None. Action - Continue to Monitor and report. Therapist to continue with developing a fall prevention</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>program. ... 12 Total complaints received, ... Trends none ... Adverse Events: Did have findings of 4 incidents, Trends - falls 3 with ER visit, 1 admitted. Action - Continue with PT for fall prevention Program." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>E. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 3rd indicates that a total of 15 clinical records were reviewed. The agency failed to evidence the 15 clinical record reviews.</p> <p>F. The document titled "Clinical Record Review Results" dated as 2011 Quarter 3rd indicates the agency's census was 83 for the quarter states, "No trends, few orders unsigned, coordination of care, few frequencies don ' t match."</p> <p>I. The document titled "PI Minutes" states, "3 rd Quarter 2011 ... 11/11/11 ... Infection Report 21 patient infections ... 13 UTI (urinary tract infections) with only one having a urinary catheter. Mediport infection reported 4 times from same patient, Trends UTI Action - Review with nurses findings. Use insert for UTI high risk patients for education. ... Occurrence Reports: 20 Patient Occurrences ... All patient</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>occurrences were falls, 17 due to loss of balance, 3 other reasons, 2 resulted in hospital admissions, 1 to ER, others no significant injuries. Action - Once PT [physical therapy] in place to research falls and develop plan. Until then, staff to monitor home safety with patients. ... Complaint / Resolution 19 reported, 10 patients, 5 on aides that patient requested new aide, some they felt was not doing good job cleaning. 9 employees, 1 employee patient was doing illegal activity, No Trends, All issues were resolved, Cont to monitor.. ... Satisfaction Surveys ... 5 returned from non - skilled with showing 1 patient doesn't feel pain is managed." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>6. On December 7, 2011, at 4 PM, employee F indicated she had not had contact with the Professional Advisory Committee (PAC) as most of the members of the PAC had left the agency. A new group was formed, but she had not had contact or meetings with the new PAC. There was not any evidence of a written ongoing agency plan or meeting meetings that document the plan for the administrative review as to how the agency was continually evaluating itself, and indicated there was no further documentation to evidence.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0245	<p>The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.</p> <p>Based on policy and administrative documents review and interview, the agency failed to ensure a plan was in place for the ongoing annual evaluation that assesses the extent to which the agency's program is appropriate, adequate, effective and efficient with the potential to effect all 73 patients served by the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Administrative documents failed to evidence the agency prioritized the resolution of any identified problems and addressed how monitoring of the effectiveness of the program would be accomplished and documented.</li> <li>2. The agency policy titled "Clinical Record Review" approval date 1/28/11 states, "A clinical record review will be conducted to determine the extent to which CJ ' s Abundant Care staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by representatives of appropriate health care</li> </ol>	G0245	<p>Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON.</p>	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	disciplines. ... Purpose: To evaluate appropriate admission and discharge. To evaluate the appropriateness, adequacy and effectiveness of services. To identify over - under utilization of services. To identify gaps in agency service, and need for in-service education, staffing, consulting services, and agency policies. To ensure records reflect care and / or service provided, the client ' s current condition, and the client ' s progress towards goals and condition at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plan s of care. To evaluate adverse outcome reports and identify documentation limitations or the need for focused plan to improve client outcomes through targeted interventions. Special Instructions: The Clinical Record Review Committee is a subcommittee of the Professional Advisory Committee. ... The responsibility for the review program is primarily assigned to the Director of Nursing / designee. The committee is responsible for client care evaluation. ... The committee shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. ... The committee shall make recommendations about specific client documentation issues to the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>administrator to review. ... The Committee shall routinely examine the findings of the previous reviews to determine focus and assure quality client care." The agency documents failed to evidence the agency had completed quarterly chart audits per agency policy since June 17, 2011.</p> <p>3. The policy titled "Performance Improvement" states, "Purpose: To improve client and agency outcomes through a coordinated collaborative approach to assessing and improving organizational structure. ... To identify deviations from CJ's and professional standards and pursue improvement opportunities by assessment, planning and evaluation. ... To reduce factors that contribute to unanticipated adverse events and / or outcomes. ... Activities for performance improvement will be the responsibility of the Administrator. Program will reflect participation by all services and all levels of staff. Data will be collected to allow the agency to monitor its performance. ... Data will be systematically collected to measure process and outcome. ... Intensive assessment will be completed when undesirable patterns or trends in performance is detected or important sentinel events are identified. The plan will target the performance of existing</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>processes and outcomes and identify / design new processes based on priorities, standards, and resources."</p> <p>4. On December 7, 2011, at 1:45 PM, employee F indicated the extent of the clinical record review and quality assurance and improvement program available was presented for review to the surveyors and the physical therapist who was to have developed a fall prevention program had left the agency and the agency management had yet to develop and implement a program.</p> <p>5. Eleven documents titled "Audit Tool" were presented as evidence of the agency's clinical record review ending with the 3rd quarter in September of 2011. Each of the 11 Audit Tools contained a patient's name and a list of items the auditor was to determine if the record had met compliance. Only 2 of the Audit Tools completed included the name of the auditor; 8 of the Audit Tools failed to identify the Recertification period in review; 5 of the Audit Tools failed to identify the date the audit was completed.</p> <p>A. One of the undated "Audit Tools" states, "485 (5/21 to 7/19/11) had diagnosis of pressure ulcer heel. She doesn't have area on heel." In another area of the same audit states, "No skilled nurse</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>ordered."</p> <p>B. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 2nd indicates that a total of 16 clinical records were reviewed. The agency failed to evidence the 16 clinical record reviews that were completed.</p> <p>C. The document titled "Clinical Record Review Results" dated as 2011 Quarter 2nd indicates the agency's census was 112 for the quarter and stated, "Items not filled out in 7 charts, patient response to teaching, coordination of care, discharge planning, aide supervision, vital signs, no orders for the Recertification. Other findings: frequency off, discharge summary not done, 60 day summary not done, wrong diagnosis, diagnosis does not match the 485, patient signatures and orders not back."</p> <p>D. The document titled "PI Minutes" states, "2 nd Quarter 2011 ... 7/14/11 ... Infection Report 26 patient infections ... Trends - 16 UTI (urinary tract infections) Action - In service aides on proper peri / cath care due to 11 /16 have anchored cathes. ... Occurrence Reports: 12 Patient reports ... 10 falls with 5 witnessed and 2 resulted in an ER visit Trends None. Action - Continue to Monitor and report. Therapist to continue</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>with developing a fall prevention program. ... 12 Total complaints received, ... Trends none ... Adverse Events: Did have findings of 4 incidents, Trends - falls 3 with ER visit, 1 admitted. Action - Continue with PT for fall prevention Program." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>E. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 3rd indicates that a total of 15 clinical records were reviewed. The agency failed to evidence the 15 clinical record reviews.</p> <p>F. The document titled "Clinical Record Review Results" dated as 2011 Quarter 3rd indicates the agency's census was 83 for the quarter states, "No trends, few orders unsigned, coordination of care, few frequencies don ' t match."</p> <p>I. The document titled "PI Minutes" states, "3 rd Quarter 2011 ... 11/11/11 ... Infection Report 21 patient infections ... 13 UTI (urinary tract infections) with only one having a urinary catheter. Mediport infection reported 4 times from same patient, Trends UTI Action - Review with nurses findings. Use insert for UTI high risk patients for education. ... Occurrence Reports: 20</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Patient Occurrences ... All patient occurrences were falls, 17 due to loss of balance, 3 other reasons, 2 resulted in hospital admissions, 1 to ER, others no significant injuries. Action - Once PT [physical therapy] in place to research falls and develop plan. Until then, staff to monitor home safety with patients. ... Complaint / Resolution 19 reported, 10 patients, 5 on aides that patient requested new aide, some they felt was not doing good job cleaning. 9 employees, 1 employee patient was doing illegal activity, No Trends, All issues were resolved, Cont to monitor.. ... Satisfaction Surveys ... 5 returned from non - skilled with showing 1 patient doesn't feel pain is managed." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>6. On December 7, 2011, at 4 PM, employee F indicated she had not had contact with the Professional Advisory Committee (PAC) as most of the members of the PAC had left the agency. A new group was formed, but she had not had contact or meetings with the new PAC. There was not any evidence of a written ongoing agency plan or meeting meetings that document the plan for the administrative review as to how the agency was continually evaluating itself, and indicated there was no further</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
G0246	<p>documentation to evidence.</p> <p>Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. Based on policy and administrative document review and interview, the agency failed to ensure a plan was in place for the ongoing evaluation that identified issues that could be reported and acted upon by those responsible for the operation of the agency for 1 of 1 agency with the potential to effect all 73 patients served by the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Administrative documents failed to evidence the agency prioritized the resolution of any identified problems and addressed how monitoring of the effectiveness of the program would be accomplished and documented.</li> <li>The agency policy titled "Clinical Record Review" approval date 1/28/11 states, "A clinical record review will be conducted to determine the extent to which CJ ' s Abundant Care staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by</li> </ol>	G0246	<p>Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON. Professional Advisory Committee has been assigned by Administrator. Members have been notified and accepted date of scheduled meeting. An annual</p>	01/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>representatives of appropriate health care disciplines. ... Purpose: To evaluate appropriate admission and discharge. To evaluate the appropriateness, adequacy and effectiveness of services. To identify over - under utilization of services. To identify gaps in agency service, and need for in-service education, staffing, consulting services, and agency policies. To ensure records reflect care and / or service provided, the client ' s current condition, and the client ' s progress towards goals and condition at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plan s of care. To evaluate adverse outcome reports and identify documentation limitations or the need for focused plan to improve client outcomes through targeted interventions. Special Instructions: The Clinical Record Review Committee is a subcommittee of the Professional Advisory Committee. ... The responsibility for the review program is primarily assigned to the Director of Nursing / designee. The committee is responsible for client care evaluation. ... The committee shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. ... The committee shall make recommendations about specific</p>		<p>calender developed for scheduled PI meetings. The POA will be presented and reviewed at annual PAC meeting. Administrator/DON will ensure recommendations made by PAC are met by goal date on POA. Revised agenda in place to meet State and Federal requirements. Each committee member shall have signed orientation sheet to PAC. Revised Annual Agency evaluation form in place. Scheduled PAC meeting .POA with every PI will be the written ongoing agency plan as to how agency will continue self evaluation.100% of active patients charts to be audited by Administrator/Clinical Coordinator/DON and any professional staff of last 2 certification periods by 1/5/2012 with Plan of action developed for findings with specific goal dates . Then Assigned audit sheets to appropriate health professionals each quarter with 10% of census ,( minimum 10) active/discharged being audited with review by DON/Alternate DON with Plan of Action developed with goals dates to address and act upon trends.Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>client documentation issues to the administrator to review. ... The Committee shall routinely examine the findings of the previous reviews to determine focus and assure quality client care." The agency documents failed to evidence the agency had completed quarterly chart audits per agency policy since June 17, 2011.</p> <p>3. The policy titled "Performance Improvement" states, "Purpose: To improve client and agency outcomes through a coordinated collaborative approach to assessing and improving organizational structure. ... To identify deviations from CJ's and professional standards and pursue improvement opportunities by assessment, planning and evaluation. ... To reduce factors that contribute to unanticipated adverse events and / or outcomes. ... Activities for performance improvement will be the responsibility of the Administrator. Program will reflect participation by all services and all levels of staff. Data will be collected to allow the agency to monitor its performance. ... Data will be systematically collected to measure process and outcome. ... Intensive assessment will be completed when undesirable patterns or trends in performance is detected or important sentinel events are identified. The plan</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>will target the performance of existing processes and outcomes and identify / design new processes based on priorities, standards, and resources."</p> <p>4. On December 7, 2011, at 1:45 PM, employee F indicated the extent of the clinical record review and quality assurance and improvement program available was presented for review to the surveyors and the physical therapist who was to have developed a fall prevention program had left the agency and the agency management had yet to develop and implement a program.</p> <p>5. Eleven documents titled "Audit Tool" were presented as evidence of the agency's clinical record review ending with the 3rd quarter in September of 2011. Each of the 11 Audit Tools contained a patient's name and a list of items the auditor was to determine if the record had met compliance. Only 2 of the Audit Tools completed included the name of the auditor; 8 of the Audit Tools failed to identify the Recertification period in review; 5 of the Audit Tools failed to identify the date the audit was completed.</p> <p>A. One of the undated "Audit Tools" states, "485 (5/21 to 7/19/11) had diagnosis of pressure ulcer heel. She doesn't have area on heel." In another area</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>of the same audit states, "No skilled nurse ordered."</p> <p>B. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 2nd indicates that a total of 16 clinical records were reviewed. The agency failed to evidence the 16 clinical record reviews that were completed.</p> <p>C. The document titled "Clinical Record Review Results" dated as 2011 Quarter 2nd indicates the agency's census was 112 for the quarter and stated, "Items not filled out in 7 charts, patient response to teaching, coordination of care, discharge planning, aide supervision, vital signs, no orders for the Recertification. Other findings: frequency off, discharge summary not done, 60 day summary not done, wrong diagnosis, diagnosis does not match the 485, patient signatures and orders not back."</p> <p>D. The document titled "PI Minutes" states, "2 nd Quarter 2011 ... 7/14/11 ... Infection Report 26 patient infections ... Trends - 16 UTI (urinary tract infections) Action - In service aides on proper peri / cath care due to 11 /16 have anchored cathes. ... Occurrence Reports: 12 Patient reports ... 10 falls with 5 witnessed and 2 resulted in an ER visit Trends None. Action - Continue to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Monitor and report. Therapist to continue with developing a fall prevention program. ... 12 Total complaints received, ... Trends none ... Adverse Events: Did have findings of 4 incidents, Trends - falls 3 with ER visit, 1 admitted. Action - Continue with PT for fall prevention Program." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>E. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 3rd indicates that a total of 15 clinical records were reviewed. The agency failed to evidence the 15 clinical record reviews.</p> <p>F. The document titled "Clinical Record Review Results" dated as 2011 Quarter 3rd indicates the agency's census was 83 for the quarter states, "No trends, few orders unsigned, coordination of care, few frequencies don ' t match."</p> <p>I. The document titled "PI Minutes" states, "3 rd Quarter 2011 ... 11/11/11 ... Infection Report 21 patient infections ... 13 UTI (urinary tract infections) with only one having a urinary catheter. Mediport infection reported 4 times from same patient, Trends UTI Action - Review with nurses findings. Use insert for UTI high risk patients for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>education. ... Occurrence Reports: 20 Patient Occurrences ... All patient occurrences were falls, 17 due to loss of balance, 3 other reasons, 2 resulted in hospital admissions, 1 to ER, others no significant injuries. Action - Once PT [physical therapy] in place to research falls and develop plan. Until then, staff to monitor home safety with patients. ... Complaint / Resolution 19 reported, 10 patients, 5 on aides that patient requested new aide, some they felt was not doing good job cleaning. 9 employees, 1 employee patient was doing illegal activity, No Trends, All issues were resolved, Cont to monitor.. ... Satisfaction Surveys ... 5 returned from non - skilled with showing 1 patient doesn't feel pain is managed." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>6. On December 7, 2011, at 4 PM, employee F indicated she had not had contact with the Professional Advisory Committee (PAC) as most of the members of the PAC had left the agency. A new group was formed, but she had not had contact or meetings with the new PAC. There was not any evidence of a written ongoing agency plan or meeting meetings that document the plan for the administrative review as to how the agency was continually evaluating itself,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0248	<p>and indicated there was no further documentation to evidence.</p> <p>As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. Based on policy and administrative document review and interview, the agency failed to ensure a plan was in place for the ongoing agency evaluation that assessed the administrative practices of the agency to determine the extent to which the agency promoted patient care that is appropriate, adequate, effective, and efficient for 1 of 1 agency with the potential to affect all 73 patients of the agency.</p> <p>The findings include:</p> <p>1. Administrative documents failed to evidence the agency conducted an annual evaluation of its program which included a review of policies and procedures and an administrative review, including criteria to prioritize the resolution of any identified problems, and address how monitoring of the effectiveness of the program would be accomplished and</p>	G0248	<p>Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form</p>	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	documented.  2. The agency policy titled "Clinical Record Review" approval date 1/28/11 states, "A clinical record review will be conducted to determine the extent to which CJ ' s Abundant Care staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by representatives of appropriate health care disciplines. ... Purpose: To evaluate appropriate admission and discharge. To evaluate the appropriateness, adequacy and effectiveness of services. To identify over - under utilization of services. To identify gaps in agency service, and need for in-service education, staffing, consulting services, and agency policies. To ensure records reflect care and / or service provided, the client ' s current condition, and the client ' s progress towards goals and condition at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plan s of care. To evaluate adverse outcome reports and identify documentation limitations or the need for focused plan to improve client outcomes through targeted interventions. Special Instructions: The Clinical Record Review		with goal dates by DON/Alternate DON. Professional Advisory Committee has been assigned by Administrator. Members have been notified and accepted date of scheduled meeting. An annual calender developed for scheduled PI meetings. The POA will be presented and reviewed at annual PAC meeting. Administrator/DON will ensure recommendations made by PAC are met by goal date on POA. Revised agenda in place to meet State and Federal requirements. Each committee member shall have signed orientation sheet to PAC. Revised Annual Agency evaluation form in place. Scheduled PAC meeting .POA with every PI will be the written ongoing agency plan as to how agency will continue self evaluation.100% of active patients charts to be audited by Administrator/Clinical Coordinator/DON and any professional staff for last two certification periods by 1/5/2012 with Plan of action developed for findings with specific goal dates . Then Assigned audit sheets to appropriate health professionals each quarter with 10% of census ,( minimum 10) active/discharged being audited with review by DON/Alternate DON with Plan of Action developed with goals dates to address and act upon trends.Recert audits to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Committee is a subcommittee of the Professional Advisory Committee. ... The responsibility for the review program is primarily assigned to the Director of Nursing / designee. The committee is responsible for client care evaluation. ... The committee shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. ... The committee shall make recommendations about specific client documentation issues to the administrator to review. ... The Committee shall routinely examine the findings of the previous reviews to determine focus and assure quality client care." The agency documents failed to evidence the agency had completed quarterly chart audits per agency policy since June 17, 2011.</p> <p>3. The policy titled "Performance Improvement" states, "Purpose: To improve client and agency outcomes through a coordinated collaborative approach to assessing and improving organizational structure. ... To identify deviations from CJ's and professional standards and pursue improvement opportunities by assessment, planning and evaluation. ... To reduce factors that contribute to unanticipated adverse events and / or outcomes. ... Activities for performance improvement will be the</p>		performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>responsibility of the Administrator. Program will reflect participation by all services and all levels of staff. Data will be collected to allow the agency to monitor its performance. ... Data will be systematically collected to measure process and outcome. ... Intensive assessment will be completed when undesirable patterns or trends in performance is detected or important sentinel events are identified. The plan will target the performance of existing processes and outcomes and identify / design new processes based on priorities, standards, and resources."</p> <p>4. The document titled "Self Evaluation Summary" dated "Year 2010" states, "Date Submitted to Professional Advisory Committee 1-28-11 Comments / Recommendations / Action Taken: See Attached PAC meeting."</p> <p>The document titled "Professional Advisory Board Meeting Minutes Date 1/28/11 Time 11 AM - 1 PM" states, "PAC committee reviewed from QA meeting held on 1/27/11. INFECTION CONTROL - ... determined that it is vital to continually educate staff and clients on universal precautions, especially hand washing. ... CUSTOMER SATISFACTION - ... The biggest complaint being that staff is not arriving</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>on time." The agency failed to evidence that they took action on the problems identified from their 2010 Annual Evaluation, as recommended by the PAC.</p> <p>5. On December 7, 2011, at 1:45 PM, employee F indicated the extent of the clinical record review and quality assurance and improvement program available was presented for review to the surveyors and the physical therapist that was to have developed a fall prevention program had left the agency and the agency management had yet to develop and implement a program."</p> <p>6. Eleven documents titled "Audit Tool" were presented as evidence of the agency's clinical record review ending with the 3rd quarter in September of 2011. Each of the 11 Audit Tools contained a patient's name and a list of items the auditor was to determine if the record had met compliance. Only 2 of the Audit Tools completed included the name of the auditor; 8 of the Audit Tools failed to identify the Recertification period in review; 5 of the Audit Tools failed to identify the date the audit was completed.</p> <p>A. One of the undated "Audit Tools" states, "485 (5/21 to 7/19/11) had diagnosis of pressure ulcer heel. She doesn't have area on heel." In another area</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>of the same audit states, "No skilled nurse ordered. "</p> <p>B. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 2nd indicates that a total of 16 clinical records were reviewed. The agency failed to evidence the 16 clinical record reviews that were completed.</p> <p>C. The document titled "Clinical Record Review Results" dated 2011, Quarter 2nd indicates the agency's census was 112 for the quarter and stated, "Items not filled out in 7 charts, patient response to teaching, coordination of care, discharge planning, aide supervision, vital signs, no orders for the Recertification. Other findings: frequency off, discharge summary not done, 60 day summary not done, wrong diagnosis, diagnosis does not match the 485, patient signatures and orders not back."</p> <p>D. The document titled "PI Minutes" states, "2 nd Quarter 2011 ... 7/14/11 ... Infection Report 26 patient infections ... Trends - 16 UTI (urinary tract infections) Action - In service aides on proper peri / cath care due to 11 /16 have anchored cathes. ... Occurrence Reports: 12 Patient reports ... 10 falls with 5 witnessed and 2 resulted in an ER visit Trends None. Action - Continue to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Monitor and report. Therapist to continue with developing a fall prevention program. ... 12 Total complaints received, ... Trends none ... Adverse Events: Did have findings of 4 incidents, Trends - falls 3 with ER visit, 1 admitted. Action - Continue with PT for fall prevention Program." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>E. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 3rd indicates that a total of 15 clinical records were reviewed. The agency failed to evidence of the 15 clinical record reviews.</p> <p>F. The document titled "Clinical Record Review Results" dated 2011 Quarter 3rd indicates the agency's census was 83 for the quarter states, "No trends, few orders unsigned, coordination of care, few frequencies don't match."</p> <p>I. The document titled "PI Minutes" states, "3 rd Quarter 2011 ... 11/11/11 ... Infection Report 21 patient infections ... 13 UTI (urinary tract infections) with only one having a urinary catheter. Mediport infection reported 4 times from same patient, Trends UTI Action - Review with nurses findings. Use insert for UTI high risk patients for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>education. ... Occurrence Reports: 20 Patient Occurrences ... All patient occurrences were falls, 17 due to loss of balance, 3 other reasons, 2 resulted in hospital admissions, 1 to ER, others no significant injuries. Action - Once PT [physical therapy] in place to research falls and develop plan. Until then, staff to monitor home safety with patients. ... Complaint / Resolution 19 reported, 10 patients, 5 on aides that patient requested new aide, some they felt was not doing good job cleaning. 9 employees, 1 employee patient was doing illegal activity, No Trends, All issues were resolved, Cont to monitor.. ... Satisfaction Surveys ... 5 returned from non - skilled with showing 1 patient doesn't feel pain is managed." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>7. On December 7, 2011, at 4 PM, employee F indicated she had not had contact with the Professional Advisory Committee (PAC) as most of the members of the PAC had left the agency. A new group was formed, but she had not had contact or meetings with the new PAC. There was not any evidence of a written ongoing agency plan or meeting meetings that document the plan for the administrative review as to how the agency was continually evaluating itself,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0249	<p>and indicated there was no further documentation to evidence.</p> <p>Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.</p> <p>Based on policy and administrative documents review and interview, the agency failed to ensure a plan was in place for collection of pertinent data to assist in evaluation for 1 of 1 agency with the potential to affect all 73 patients of the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Administrative documents failed to evidence the agency conducted an annual evaluation of its program which included a review of policies and procedures and an administrative review, including criteria to prioritize the resolution of any identified problems, and address how monitoring of the effectiveness of the program would be accomplished and documented.</li> <li>The agency policy titled "Clinical Record Review" approval date 1/28/11 states, "A clinical record review will be conducted to determine the extent to</li> </ol>	G0249	<p>Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON. Professional Advisory</p>	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>which CJ ' s Abundant Care staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by representatives of appropriate health care disciplines. ... Purpose: To evaluate appropriate admission and discharge. To evaluate the appropriateness, adequacy and effectiveness of services. To identify over - under utilization of services. To identify gaps in agency service, and need for in-service education, staffing, consulting services, and agency policies. To ensure records reflect care and / or service provided, the client ' s current condition, and the client ' s progress towards goals and condition at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plan s of care. To evaluate adverse outcome reports and identify documentation limitations or the need for focused plan to improve client outcomes through targeted interventions. Special Instructions: The Clinical Record Review Committee is a subcommittee of the Professional Advisory Committee. ... The responsibility for the review program is primarily assigned to the Director of Nursing / designee. The committee is responsible for client care evaluation. ...</p>		<p>Committee has been assigned by Administrator. Members have been notified and accepted date of scheduled meeting. An annual calender developed for scheduled PI meetings. The POA will be presented and reviewed at annual PAC meeting. Administrator/DON will ensure recommendations made by PAC are met by goal date on POA. Revised agenda in place to meet State and Federal requirements. Each committee member shall have signed orientation sheet to PAC. Revised Annual Agency evaluation form in place. Scheduled PAC meeting .POA with every PI will be the written ongoing agency plan as to how agency will continue self evaluation.100% of active patients charts to be audited by Administrator/Clinical Coordinator/DON and any professional staff for last two certification periods by 1/5/2012 with Plan of action developed for findings with specific goal dates . Then Assigned audit sheets to appropriate health professionals each quarter with 10% of census ,( minimum 10) active/discharged being audited with review by DON/Alternate DON with Plan of Action developed with goals dates to address and act upon trends.Recert audits to be performed at end of each 60 day episode by Clinical Coordinator</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The committee shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. ... The committee shall make recommendations about specific client documentation issues to the administrator to review. ... The Committee shall routinely examine the findings of the previous reviews to determine focus and assure quality client care." The agency documents failed to evidence the agency had completed quarterly chart audits per agency policy since June 17, 2011.</p> <p>3. The policy titled "Performance Improvement" states, "Purpose: To improve client and agency outcomes through a coordinated collaborative approach to assessing and improving organizational structure. ... To identify deviations from CJ's and professional standards and pursue improvement opportunities by assessment, planning and evaluation. ... To reduce factors that contribute to unanticipated adverse events and / or outcomes. ... Activities for performance improvement will be the responsibility of the Administrator. Program will reflect participation by all services and all levels of staff. Data will be collected to allow the agency to monitor its performance. ... Data will be systematically collected to measure</p>		and filed on site. Any trends shall be placed on Plan of Action form with goal dates.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>process and outcome. ... Intensive assessment will be completed when undesirable patterns or trends in performance is detected or important sentinel events are identified. The plan will target the performance of existing processes and outcomes and identify / design new processes based on priorities, standards, and resources."</p> <p>4. The document titled "Self Evaluation Summary" dated "Year 2010" states, "Date Submitted to Professional Advisory Committee 1-28-11 Comments / Recommendations / Action Taken: See Attached PAC meeting."</p> <p>The document titled "Professional Advisory Board Meeting Minutes Date 1/28/11 Time 11 AM - 1 PM" states, "PAC committee reviewed from QA meeting held on 1/27/11. INFECTION CONTROL - ... determined that it is vital to continually educate staff and clients on universal precautions, especially hand washing. ... CUSTOMER SATISFACTION - ... The biggest complaint being that staff is not arriving on time." The agency failed to evidence that they took action on the problems identified from their 2010 Annual Evaluation, as recommended by the PAC.</p> <p>5. On December 7, 2011, at 1:45 PM,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>employee F indicated the extent of the clinical record review and quality assurance and improvement program available was presented for review to the surveyors and the physical therapist that was to have developed a fall prevention program had left the agency and the agency management had yet to develop and implement a program."</p> <p>6. Eleven documents titled "Audit Tool" were presented as evidence of the agency's clinical record review ending with the 3rd quarter in September of 2011. Each of the 11 Audit Tools contained a patient's name and a list of items the auditor was to determine if the record had met compliance. Only 2 of the Audit Tools completed included the name of the auditor; 8 of the Audit Tools failed to identify the Recertification period in review; 5 of the Audit Tools failed to identify the date the audit was completed.</p> <p>A. One of the undated "Audit Tools" states, "485 (5/21 to 7/19/11) had diagnosis of pressure ulcer heel. She doesn't have area on heel." In another area of the same audit states, "No skilled nurse ordered. "</p> <p>B. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 2nd indicates that a total of 16</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>clinical records were reviewed. The agency failed to evidence the 16 clinical record reviews that were completed.</p> <p>C. The document titled "Clinical Record Review Results" dated 2011, Quarter 2nd indicates the agency's census was 112 for the quarter and stated, "Items not filled out in 7 charts, patient response to teaching, coordination of care, discharge planning, aide supervision, vital signs, no orders for the Recertification. Other findings: frequency off, discharge summary not done, 60 day summary not done, wrong diagnosis, diagnosis does not match the 485, patient signatures and orders not back."</p> <p>D. The document titled "PI Minutes" states, "2 nd Quarter 2011 ... 7/14/11 ... Infection Report 26 patient infections ... Trends - 16 UTI (urinary tract infections) Action - In service aides on proper peri / cath care due to 11 /16 have anchored cathes. ... Occurrence Reports: 12 Patient reports ... 10 falls with 5 witnessed and 2 resulted in an ER visit Trends None. Action - Continue to Monitor and report. Therapist to continue with developing a fall prevention program. ... 12 Total complaints received, ... Trends none ... Adverse Events: Did have findings of 4 incidents, Trends - falls 3 with ER visit, 1 admitted. Action -</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>Continue with PT for fall prevention Program." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>E. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 3rd indicates that a total of 15 clinical records were reviewed. The agency failed to evidence of the 15 clinical record reviews.</p> <p>F. The document titled "Clinical Record Review Results" dated 2011 Quarter 3rd indicates the agency's census was 83 for the quarter states, "No trends, few orders unsigned, coordination of care, few frequencies don't match."</p> <p>I. The document titled "PI Minutes" states, "3 rd Quarter 2011 ... 11/11/11 ... Infection Report 21 patient infections ... 13 UTI (urinary tract infections) with only one having a urinary catheter. Mediport infection reported 4 times from same patient, Trends UTI Action - Review with nurses findings. Use insert for UTI high risk patients for education. ... Occurrence Reports: 20 Patient Occurrences ... All patient occurrences were falls, 17 due to loss of balance, 3 other reasons, 2 resulted in hospital admissions, 1 to ER, others no significant injuries. Action - Once PT</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>[physical therapy] in place to research falls and develop plan. Until then, staff to monitor home safety with patients. ... Complaint / Resolution 19 reported, 10 patients, 5 on aides that patient requested new aide, some they felt was not doing good job cleaning. 9 employees, 1 employee patient was doing illegal activity, No Trends, All issues were resolved, Cont to monitor.. ... Satisfaction Surveys ... 5 returned from non - skilled with showing 1 patient doesn't feel pain is managed." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>7. On December 7, 2011, at 4 PM, employee F indicated she had not had contact with the Professional Advisory Committee (PAC) as most of the members of the PAC had left the agency. A new group was formed, but she had not had contact or meetings with the new PAC. There was not any evidence of a written ongoing agency plan or meeting meetings that document the plan for the administrative review as to how the agency was continually evaluating itself, and indicated there was no further documentation to evidence.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
G0250	<p>At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.</p> <p>Based on document and policy review and interview, the agency failed to ensure quarterly chart audits were conducted as part of the evaluation process for 1 of 1 agency with the potential to affect all 73 patients of the agency.</p> <p>Findings include:</p> <p>1. The agency policy titled "Clinical Record Review" approval date 1/28/11 states, "A clinical record review will be conducted to determine the extent to which CJ ' s Abundant Care staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by representatives of appropriate health care disciplines. ... Purpose: To evaluate appropriate admission and discharge. To evaluate the appropriateness, adequacy and effectiveness of services. To identify over - under utilization of services. To identify gaps in agency service, and need for in-service education, staffing, consulting services, and agency policies. To ensure records reflect care and / or</p>	G0250	<p>Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON. Professional Advisory Committee has been assigned by Administrator. Members have been notified and accepted date of scheduled meeting. An annual</p>	01/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>service provided, the client's current condition, and the client ' s progress towards goals and condition at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plan s of care. To evaluate adverse outcome reports and identify documentation limitations or the need for focused plan to improve client outcomes through targeted interventions. Special Instructions: The Clinical Record Review Committee is a subcommittee of the Professional Advisory Committee. ... The responsibility for the review program is primarily assigned to the Director of Nursing / designee. The committee is responsible for client care evaluation. ... The committee shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. ... The committee shall make recommendations about specific client documentation issues to the administrator to review. ... The Committee shall routinely examine the findings of the previous reviews to determine focus and assure quality client care." The agency documents failed to evidence the agency had completed quarterly chart audits per agency policy since June 17, 2011.</p>		<p>calender developed for scheduled PI meetings. The POA will be presented and reviewed at annual PAC meeting. Administrator/DON will ensure recommendations made by PAC are met by goal date on POA. Revised agenda in place to meet State and Federal requirements. Each committee member shall have signed orientation sheet to PAC. Revised Annual Agency evaluation form in place. Scheduled PAC meeting .POA with every PI will be the written ongoing agency plan as to how agency will continue self evaluation.100% of active patients charts to be audited by Administrator/Clinical Coordinator/DON and any professional staff for last two certification periods by 1/5/2012 with Plan of action developed for findings with specific goal dates . Then Assigned audit sheets to appropriate health professionals each quarter with 10% of census ,( minimum 10) active/discharged being audited with review by DON/Alternate DON with Plan of Action developed with goals dates to address and act upon trends.Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. On December 7, 2011, at 1:45 PM, employee F indicated the extent of the clinical record review and quality assurance and improvement program available was presented for review to the surveyors and the physical therapist that was to have developed a fall prevention program had left the agency and the agency management had yet to develop and implement a program."</p> <p>3. Eleven documents titled "Audit Tool" were presented as evidence of the agency's clinical record review ending with the 3rd quarter in September of 2011. Each of the 11 Audit Tools contained a patient's name and a list of items the auditor was to determine if the record had met compliance. Only 2 of the Audit Tools completed included the name of the auditor; 8 of the Audit Tools failed to identify the Recertification period in review; 5 of the Audit Tools failed to identify the date the audit was completed.</p> <p>A. One of the undated "Audit Tools" states, "485 (5/21 to 7/19/11) had diagnosis of pressure ulcer heel. She doesn't have area on heel." In another area of the same audit states, "No skilled nurse ordered. "</p> <p>B. The document titled "Clinical Record Review Roster" dated as 2011</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Quarter 2nd indicates that a total of 16 clinical records were reviewed. The agency failed to evidence the 16 clinical record reviews that were completed.</p> <p>C. The document titled "Clinical Record Review Results" dated 2011, Quarter 2nd indicates the agency's census was 112 for the quarter and stated, "Items not filled out in 7 charts, patient response to teaching, coordination of care, discharge planning, aide supervision, vital signs, no orders for the Recertification. Other findings: frequency off, discharge summary not done, 60 day summary not done, wrong diagnosis, diagnosis does not match the 485, patient signatures and orders not back."</p> <p>D. The document titled "PI Minutes" states, "2 nd Quarter 2011 ... 7/14/11 ... Infection Report 26 patient infections ... Trends - 16 UTI (urinary tract infections) Action - In service aides on proper peri / cath care due to 11 /16 have anchored cath. ... Occurrence Reports: 12 Patient reports ... 10 falls with 5 witnessed and 2 resulted in an ER visit Trends None. Action - Continue to Monitor and report. Therapist to continue with developing a fall prevention program. ... 12 Total complaints received, ... Trends none ... Adverse Events: Did have findings of 4 incidents, Trends - falls</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>3 with ER visit, 1 admitted. Action - Continue with PT for fall prevention Program." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>E. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 3rd indicates that a total of 15 clinical records were reviewed. The agency failed to evidence of the 15 clinical record reviews.</p> <p>F. The document titled "Clinical Record Review Results" dated 2011 Quarter 3rd indicates the agency's census was 83 for the quarter states, "No trends, few orders unsigned, coordination of care, few frequencies don't match."</p> <p>I. The document titled "PI Minutes" states, "3 rd Quarter 2011 ... 11/11/11 ... Infection Report 21 patient infections ... 13 UTI (urinary tract infections) with only one having a urinary catheter. Mediport infection reported 4 times from same patient, Trends UTI Action - Review with nurses findings. Use insert for UTI high risk patients for education. ... Occurrence Reports: 20 Patient Occurrences ... All patient occurrences were falls, 17 due to loss of balance, 3 other reasons, 2 resulted in hospital admissions, 1 to ER, others no</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
G0251	<p>significant injuries. Action - Once PT [physical therapy] in place to research falls and develop plan. Until then, staff to monitor home safety with patients. ... Complaint / Resolution 19 reported, 10 patients, 5 on aides that patient requested new aide, some they felt was not doing good job cleaning. 9 employees, 1 employee patient was doing illegal activity, No Trends, All issues were resolved, Cont to monitor.. ... Satisfaction Surveys ... 5 returned from non - skilled with showing 1 patient doesn't feel pain is managed." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>4. The agency documents failed to evidence the agency had completed chart audits per agency policy since June 17, 2011.</p> <p>There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.</p> <p>Based on document review and interview, the agency failed to ensure a continuing review of clinical records was completed to determine adequacy of the plan of care and appropriateness of continuation of care for each</p>	G0251	100% of active patients charts to be audited by Administrator/Clinical Coordinator/DON and any professional staff of last two certification periods by 1/5/2012 with Plan of action	01/05/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>60 day period a patient receives services for 1 of 1 agency.</p> <p>Findings include:</p> <p>1. The agency policy titled "Clinical Record Review" approval date 1/28/11 states, "A clinical record review will be conducted to determine the extent to which CJ ' s Abundant Care staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by representatives of appropriate health care disciplines. ... Purpose: To evaluate appropriate admission and discharge. To evaluate the appropriateness, adequacy and effectiveness of services. To identify over - under utilization of services. To identify gaps in agency service, and need for in-service education, staffing, consulting services, and agency policies. To ensure records reflect care and / or service provided, the client's current condition, and the client ' s progress towards goals and condition at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plan s of care. To evaluate adverse outcome reports and identify documentation limitations or the need for</p>		<p>developed for findings with specific goal dates . Then Assigned audit sheets to appropriate health professionals each quarter with 10% of census ,( mininum 10) active/discharged being audited with review by DON/Alternate DON with Plan of Action developed with goals dates to address and act upon trends.Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>focused plan to improve client outcomes through targeted interventions. Special Instructions: The Clinical Record Review Committee is a subcommittee of the Professional Advisory Committee. ... The responsibility for the review program is primarily assigned to the Director of Nursing / designee. The committee is responsible for client care evaluation. ... The committee shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. ... The committee shall make recommendations about specific client documentation issues to the administrator to review. ... The Committee shall routinely examine the findings of the previous reviews to determine focus and assure quality client care." The agency documents failed to evidence the agency had completed chart audits per agency policy since June 17, 2011.</p> <p>2. On December 7, 2011, at 1:45 PM, employee F indicated the extent of the clinical record review and quality assurance and improvement program available was presented for review to the surveyors and the physical therapist that was to have developed a fall prevention program had left the agency and the agency management had yet to develop and implement a program."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>3. Eleven documents titled "Audit Tool" were presented as evidence of the agency's clinical record review ending with the 3rd quarter in September of 2011. Each of the 11 Audit Tools contained a patient's name and a list of items the auditor was to determine if the record had met compliance. Only 2 of the Audit Tools completed included the name of the auditor; 8 of the Audit Tools failed to identify the Recertification period in review; 5 of the Audit Tools failed to identify the date the audit was completed.</p> <p>A. One of the undated "Audit Tools" states, "485 (5/21 to 7/19/11) had diagnosis of pressure ulcer heel. She doesn't have area on heel." In another area of the same audit states, "No skilled nurse ordered. "</p> <p>B. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 2nd indicates that a total of 16 clinical records were reviewed. The agency failed to evidence the 16 clinical record reviews that were completed.</p> <p>C. The document titled "Clinical Record Review Results" dated 2011, Quarter 2nd indicates the agency's census was 112 for the quarter and stated, "Items not filled out in 7 charts, patient response</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
	<p>to teaching, coordination of care, discharge planning, aide supervision, vital signs, no orders for the Recertification. Other findings: frequency off, discharge summary not done, 60 day summary not done, wrong diagnosis, diagnosis does not match the 485, patient signatures and orders not back."</p> <p>D. The document titled "PI Minutes" states, "2 nd Quarter 2011 ... 7/14/11 ... Infection Report 26 patient infections ... Trends - 16 UTI (urinary tract infections) Action - In service aides on proper peri / cath care due to 11 /16 have anchored cathes. ... Occurrence Reports: 12 Patient reports ... 10 falls with 5 witnessed and 2 resulted in an ER visit Trends None. Action - Continue to Monitor and report. Therapist to continue with developing a fall prevention program. ... 12 Total complaints received, ... Trends none ... Adverse Events: Did have findings of 4 incidents, Trends - falls 3 with ER visit, 1 admitted. Action - Continue with PT for fall prevention Program." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>E. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 3rd indicates that a total of 15 clinical records were reviewed. The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>agency failed to evidence of the 15 clinical record reviews.</p> <p>F. The document titled "Clinical Record Review Results" dated 2011 Quarter 3rd indicates the agency's census was 83 for the quarter states, "No trends, few orders unsigned, coordination of care, few frequencies don't match."</p> <p>I. The document titled "PI Minutes" states, "3 rd Quarter 2011 ... 11/11/11 ... Infection Report 21 patient infections ... 13 UTI (urinary tract infections) with only one having a urinary catheter. Mediport infection reported 4 times from same patient, Trends UTI Action - Review with nurses findings. Use insert for UTI high risk patients for education. ... Occurrence Reports: 20 Patient Occurrences ... All patient occurrences were falls, 17 due to loss of balance, 3 other reasons, 2 resulted in hospital admissions, 1 to ER, others no significant injuries. Action - Once PT [physical therapy] in place to research falls and develop plan. Until then, staff to monitor home safety with patients. ... Complaint / Resolution 19 reported, 10 patients, 5 on aides that patient requested new aide, some they felt was not doing good job cleaning. 9 employees, 1 employee patient was doing illegal activity, No Trends, All issues were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0330	<p>resolved, Cont to monitor.. ... Satisfaction Surveys ... 5 returned from non - skilled with showing 1 patient doesn't feel pain is managed." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and policy review and interview, it was determined the agency failed to ensure the registered nurse did the initial evaluation in 3 of 3 clinical records reviewed of patients with skilled services since the recertification</p>	G0330	100% of Nurses in-serviced on OASIS policy including SOC, RECERT, Resumptions, D/C and a SCIC.All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered.	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>survey 7/11 with the potential to affect all new patients of the agency (See G 331), failed to ensure the registered nurse reevaluated the patient after a significant change condition in 1 of 1 record reviewed of patients with a significant change in condition with the potential to affect all the agency's patients (See G 338), and failed to ensure the registered nurse completed a recertification comprehensive assessment in 5 of 5 clinical records reviewed of patients receiving services over 60 days with the potential to affect all the agency's patients who receive services longer than 60 days (See G 339).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to provide a patient-specific, comprehensive assessment that accurately reflected the patient's health status and to meet the requirements of the Condition of Participation 484.55: Comprehensive Assessment potentially affecting all 73 patients of the agency.</p>		When data entry complete and locked Data entry employee will file Original assessments into patients chart. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON to ensure appropriate assessment being completed including SCIC.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0331	<p>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.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse did the initial evaluation in 3 of 3 clinical records reviewed of patients with skilled services since the recertification survey 7/11 with the potential to affect all new patients of the agency. (4, 6, and 7)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record 4, start of care (SOC) 10/27/11, evidenced a plan of care for the certification period 10/27/11 to 12/25/11 with orders for skilled nursing and home health aide services. The clinical record failed to evidence an initial assessment by the registered nurse.</li> <li>2. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 10/5/11-12/3/11 with orders for skilled nursing, home health aide, and physical therapy services. The clinical record failed to evidence an initial assessment by the registered nurse.</li> <li>3. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the</li> </ol>	G0331	100% of Nurses in-serviced on OASIS policy including SOC, RECERT, Resumptions, D/C and a SCIC. All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. When data entry complete and locked Data entry employee will file Original assessments into patients chart.	12/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0338	<p>certification period 8/4/11 to 10/2/11 with orders for skilled nursing, home health aide, occupational therapy, physical therapy, attendant care and homemaker services. The clinical record failed to evidence a initial assessment by the registered nurse.</p> <p>4. December 5, 2011, at 12 PM, the Clinical Coordinator Employee E indicated all assessment forms had been shredded and the only forms available were computer generated Oasis forms.</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse reevaluated the patient after a significant change condition in 1 of 1 record reviewed of patients with a significant change in condition with the potential to affect all the agency's patients. (#8)</p> <p>Findings:</p>	G0338	<p>100% of Nurses in-serviced on OASIS policy including SOC, RECERT, Resumptions, D/C and a SCIC.All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. When data entry complete and locked Data entry employee will file Original assessments into patients chart. 100% of nursing notes will be</p>	12/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>1. Clinical Record # 8, start of care 8/4/11, evidenced a plan of care for the certification period 10/3/11 through 12/1/11 with orders for the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The clinical record evidenced a skilled nurse visit note dated 10/31/11 at 4 PM, written by employee I, that states, "Client seized for about 5 minutes, ... medics alerted, ... transferred per ambulance to hospital." The clinical record failed to evidence a visit note or a missed visit notification for 11/1/11. The clinical record evidenced a skilled nurse visit note dated 11/2/11 written by employee I which indicates the patient was home on 11/2/11. The clinical record failed to evidence an other follow up assessment was completed when the patient returned home from the seizure episode.</p> <p>On December 7, 2011, at 4:05 PM, employee F indicated there was not a reassessment of the patient upon return from the seizure episode nor was there sufficient documentation in the clinical record to know when the patient returned home from the hospital, the condition of the patient upon return, or what treatment the patient received.</p> <p>2. A policy approved 1/28/11, "Client</p>		<p>audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON to ensure appropriate assessment being completed including SCIC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Reassessment/Update of Comprehensive Assessment", C-155, states, "The Comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status. ... Reassessments must be done at least: 1. Every second calendar month beginning with start of care (within last 5 days of the episode, including day 60), 2. Within 48 hours of (or knowledge of) client return home from hospital admission of more than 24 hours for any reason other than diagnostic testing or other changes representing a SCIC (Significant Change in Condition) . 3. Within 48 hours of (or knowledge of ) discharge or transfer."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0339	<p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse completed a recertification comprehensive assessment in 5 of 5 clinical records reviewed of patients receiving services over 60 days with the potential to affect all the agency's patients who receive services longer than 60 days. (#6, 7, 8, 9 and 10)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 12/4/11 to 2/2/12 with orders for skilled nursing, home health aide, and physical therapy. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment.</li> <li>2. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the certification period 10/3/11 to 12/1/11 with orders for skilled nursing, home</li> </ol>	G0339	<p>100% of Nursing staff in-serviced on recertification, reassessment for 60 day episode, post hospital, or significant change in condition. Clinical Coordinator/DON/Alternate DON will review 100% of assessments of professional documentation to ensure compliance. Audit form revised to include patient name, auditors name/title and certification period being audited. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates. All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. When data entry complete and locked Data entry employee will file Original assessments into patients chart. In-serviced internal staff for record retention of documents.</p>	12/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>health aide, physical therapy, attendant care, and homemaker. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment.</p> <p>3. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned start of care assessment dated 8/4/11. The recertification assessment dated 9/28/11 was also unsigned.</p> <p>4. Clinical record 9, SOC 3/17/11, evidenced a plan of care for the certification periods 7/15/11 to 9/12/11, 9/13/11 to 11/11/11, and 11/12/11 to 1/10/12. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment for the certification periods identified.</p> <p>5. Clinical record 10, SOC 4/25/10, evidenced a plan of care for the certification periods 8/18/11 to 10/16/11 and 10/17/11 to 12/15/11. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment for the certification periods identified.</p> <p>6. December 5, 2011, at 12 PM, the Clinical Coordinator, Employee E, indicated all assessment forms had been</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0446	<p>shredded and the only forms available were computer generated Oasis forms.</p> <p>7. The policy titled "Client Reassessment / Update of the Comprehensive Assessment" states, The comprehensive assessment will be updated and revised as often as the clients condition warrants due to a major decline ... Within 48 hours of or knowledge of client return from a hospital admission of more than 24 hours, ... or other changes representing a SCIC (significant change in condition). PURPOSE To identify decline or improvement in health status, modify the plan of care and document changes that may affect care and reimbursement."</p> <p>Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations.</p> <p>Based on personnel record review and interview, the administrator failed to ensure a the employee was oriented by an appropriate person for 3 of 4 records reviewed of professional staff (A, C, E, and I) and annual evaluations were completed for 12 of 13 home health aide</p>	N0446	<p>On 12/12/2011 Administrator resigned. Alternate DON replaced, Board of Directors appointed new Administrator/Alternate DON: Sonya Welch BSN RN On 12/12/2011 Human Resource Manager was terminated and new employee assigned and oriented to position.12/12/2011</p>	12/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>records reviewed (J, K, L, Q, R, S, T, U, V, W, X, AA) with the potential to affect all the agency's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Personnel record A evidenced the physical therapist orientation being performed by the agency consultant.</li> <li>2. Personnel record C evidenced the physical therapist orientation being performed by human resource personnel.</li> <li>3. Personnel record E evidenced the registered nurse and clinical coordinator orientation being performed by human resource personnel.</li> <li>4. Personnel records J, K, L, Q, R, S, T, U, V, W, X, and AA, all home health aides, evidenced the orientation was conducted at a different agency and faxed to this agency. All orientations were signed by the scheduler.</li> <li>5. December 8, 2011, at 3:30 PM, the home health aide scheduler, employee BB, indicated the forms had been faxed from a different agency and were not performed at this agency.</li> </ol>		<p>Clinical Coordinator replaced with experienced Home Health Care RNNew orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/NursesReview P&amp;P: 1. Wound Care2. Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6. Physician Orders7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervison14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesChart Audit with reviewSelf Skills CheckOn site visit with Clinical Coordinator/DON/Alternate DON x2 within 30 daysPsuedo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific)Non-professionals:Will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0456	<p>Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following:</p> <p>(1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care.</p> <p>(2) Resolve identified problems.</p> <p>(3) Improve patient care.</p> <p>Based on document review, policy review, and interview, the administrator failed to ensure the ongoing quality assurance program was designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care.</p>	N0456	<p>be skills checked by contracted qualified RNCompetency testedAnnual evaluations to be performed on site by employees of CJs Abundant Care Clinical Coordinator/DON/Administrator. Utilizing new process: The employee anniversary date will be tracked in Software and pulled previous month to perform evaluations for upcoming month.100% of Home Health Aides where given an annual performance re-evaluation by Clinical Coordinator/DON 100% of New Personnel orientation will be reviewed by Administrator/Alternate Administrator/DON/Alternate DON to ensure compliance of new orientation process.</p> <p>To ensure compliance:Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be</p>	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Findings include:  1. The agency policy titled "Clinical Record Review" approval date 1/28/11 states, "A clinical record review will be conducted to determine the extent to which CJ ' s Abundant Care staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by representatives of appropriate health care disciplines. ... Purpose: To evaluate appropriate admission and discharge. To evaluate the appropriateness, adequacy and effectiveness of services. To identify over - under utilization of services. To identify gaps in agency service, and need for in-service education, staffing, consulting services, and agency policies. To ensure records reflect care and / or service provided, the client ' s current condition, and the client ' s progress towards goals and condition at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plan s of care. To evaluate adverse outcome reports and identify documentation limitations or the need for focused plan to improve client outcomes through targeted interventions. Special Instructions: The Clinical Record Review		audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON and reviewed by Administrator/Alternate Administrator. In-serviced SN of following policies and procedures: 1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders/Physician Notification 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care Plan/Documentation 10. Client Admission 11. Oasis Policy 12. Plan of Care 13. Medical Supervision 14. In-services 15. Pressure Ulcer Prevention 16. Pain Management 17. Skilled Nursing Services Physician Verbal Order form changed to include VO date and time on 12/9/2011 Clinical Coordinator/DON/Alternate		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Committee is a subcommittee of the Professional Advisory Committee. ... The responsibility for the review program is primarily assigned to the Director of Nursing / designee. The committee is responsible for client care evaluation. ... The committee shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. ... The committee shall make recommendations about specific client documentation issues to the administrator to review. ... The Committee shall routinely examine the findings of the previous reviews to determine focus and assure quality client care." The agency documents failed to evidence the agency had completed quarterly chart audits per agency policy since June 17, 2011.</p> <p>2. The policy titled "Performance Improvement" states, "Purpose: To improve client and agency outcomes through a coordinated collaborative approach to assessing and improving organizational structure. ... To identify deviations from CJ's and professional standards and pursue improvement opportunities by assessment, planning and evaluation. ... To reduce factors that contribute to unanticipated adverse events and / or outcomes. ... Activities for performance improvement will be the</p>		<p>DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care. To ensure compliance by weekly case conference. Policy revision of Physicians Orders completed. All SN providing care are to receive copy of Plan of CarePhysicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax.Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. .Original assessments will be filed in patients chart after data entry and locking by Data entry employee.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>responsibility of the Administrator. Program will reflect participation by all services and all levels of staff. Data will be collected to allow the agency to monitor its performance. ... Data will be systematically collected to measure process and outcome. ... Intensive assessment will be completed when undesirable patterns or trends in performance is detected or important sentinel events are identified. The plan will target the performance of existing processes and outcomes and identify / design new processes based on priorities, standards, and resources."</p> <p>3. On December 7, 2011, at 1:45 PM, employee F indicated the extent of the clinical record review and quality assurance and improvement program available was presented for review to the surveyors and the physical therapist who was to have developed a fall prevention program had left the agency and the agency management had yet to develop and implement a program.</p> <p>4. Eleven documents titled "Audit Tool" were presented as evidence of the agency's clinical record review ending with the 3rd quarter in September of 2011. Each of the 11 Audit Tools contained a patient's name and a list of items the auditor was to determine if the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>record had met compliance. Only 2 of the Audit Tools completed included the name of the auditor; 8 of the Audit Tools failed to identify the Recertification period in review; 5 of the Audit Tools failed to identify the date the audit was completed.</p> <p>A. One of the undated "Audit Tools" states, "485 (5/21 to 7/19/11) had diagnosis of pressure ulcer heel. She doesn't have area on heel." In another area of the same audit states, "No skilled nurse ordered."</p> <p>B. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 2nd indicates that a total of 16 clinical records were reviewed. The agency failed to evidence the 16 clinical record reviews that were completed.</p> <p>C. The document titled "Clinical Record Review Results" dated as 2011 Quarter 2nd indicates the agency's census was 112 for the quarter and stated, "Items not filled out in 7 charts, patient response to teaching, coordination of care, discharge planning, aide supervision, vital signs, no orders for the Recertification. Other findings: frequency off, discharge summary not done, 60 day summary not done, wrong diagnosis, diagnosis does not match the 485, patient signatures and orders not back."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>D. The document titled "PI Minutes" states, "2 nd Quarter 2011 ... 7/14/11 ... Infection Report 26 patient infections ... Trends - 16 UTI (urinary tract infections) Action - In service aides on proper peri / cath care due to 11 /16 have anchored cathes. ... Occurrence Reports: 12 Patient reports ... 10 falls with 5 witnessed and 2 resulted in an ER visit Trends None. Action - Continue to Monitor and report. Therapist to continue with developing a fall prevention program. ... 12 Total complaints received, ... Trends none ... Adverse Events: Did have findings of 4 incidents, Trends - falls 3 with ER visit, 1 admitted. Action - Continue with PT for fall prevention Program." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>E. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 3rd indicates that a total of 15 clinical records were reviewed. The agency failed to evidence the 15 clinical record reviews.</p> <p>F. The document titled "Clinical Record Review Results" dated as 2011 Quarter 3rd indicates the agency's census was 83 for the quarter states, "No trends, few orders unsigned, coordination of care,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>few frequencies don ' t match."</p> <p>I. The document titled "PI Minutes" states, "3 rd Quarter 2011 ... 11/11/11 ... Infection Report 21 patient infections ... 13 UTI (urinary tract infections) with only one having a urinary catheter. Mediport infection reported 4 times from same patient, Trends UTI Action - Review with nurses findings. Use insert for UTI high risk patients for education. ... Occurrence Reports: 20 Patient Occurrences ... All patient occurrences were falls, 17 due to loss of balance, 3 other reasons, 2 resulted in hospital admissions, 1 to ER, others no significant injuries. Action - Once PT [physical therapy] in place to research falls and develop plan. Until then, staff to monitor home safety with patients. ... Complaint / Resolution 19 reported, 10 patients, 5 on aides that patient requested new aide, some they felt was not doing good job cleaning. 9 employees, 1 employee patient was doing illegal activity, No Trends, All issues were resolved, Cont to monitor.. ... Satisfaction Surveys ... 5 returned from non - skilled with showing 1 patient doesn't feel pain is managed." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>5. On December 7, 2011, at 4 PM,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
N0458	<p>employee F indicated she had not had contact with the Professional Advisory Committee (PAC) as most of the members of the PAC had left the agency. A new group was formed, but she had not had contact or meetings with the new PAC. There was not any evidence of a written ongoing agency plan or meeting meetings that document the plan for the administrative review as to how the agency was continually evaluating itself, and indicated there was no further documentation to evidence.</p> <p>Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <ol style="list-style-type: none"> <li>(1) Receipt of job description.</li> <li>(2) Qualifications.</li> <li>(3) A copy of limited criminal history pursuant to IC 16-27-2.</li> <li>(4) A copy of current license, certification, or registration.</li> <li>(5) Annual performance evaluations.</li> </ol> <p>Based on personnel record review and interview, the agency failed to ensure an orientation was performed by the appropriate staff for 3 of 4 records</p>	N0458	100% of personnel files have been audited, 20% of personnel files or minimum of 10 records will continue to be audited for TB, Home Health Aide certification, Limited Criminal History, Performance Evaluations, Job	12/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>reviewed of professional staff (A, C, and E) and 12 of 13 home health aide files reviewed (J, K, L, Q, R, S, T, U, V,W, X, AA)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Personnel record A evidenced the physical therapist orientation being performed by the agency consultant.</li> <li>Personnel record C evidenced the physical therapist orientation being performed by human resource personnel.</li> <li>Personnel record E evidenced the registered nurse and clinical coordinator orientation being performed by human resource personnel.</li> <li>Personnel records J, K, L, Q, R, S, T, U, V, W, X, and AA, all home health aides, evidenced the orientation was conducted at a different agency and faxed to this agency. All orientations were signed by the scheduler.</li> <li>December 8, 2011, at 3:30 PM, the home health aide scheduler, employee BB, indicated the forms had been faxed from a different agency and were not performed at this agency.</li> </ol>		<p>descriptions, and qualifications quarterly for Performance Improvement. Audits to be performed by HR Supervisor. Administrator/DON will audit 100% of all new personnel files before first patient contact. To ensure Indiana State-Federal requirements are met. New orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/NursesReview P&amp;P: 1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesChart Audit with reviewSelf Skills CheckOn site visit with Clinical Coordinator/DON/Alternate DON x2 within 30 daysPsuedo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
			Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific)Non-professionals:Will be skills checked by contracted qualified RNCompetency testedAnnual evaluations to be performed on site by employees of CJs Abundant Care Clinical Coordinator/DON/Administrator. Utilizing new process: The employee anniversary date will be tracked in Software and pulled previous month to perform evaluations for upcoming month.100% of Home Health Aides where given an annual performance re-evaluation by Clinical Coordinator/DON 100% of New Personnel orientation will be reviewed by Administrator/Alternate Administrator/DON/Alternate DON to ensure compliance of new orientation process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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; 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; unless approved by a physician to work.</p> <p>(6) The home health agency must maintain</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>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 clinical record and interview the agency failed to ensure the occupational therapist completed a "Questionnaire for Positive TB Skin Test Reactions" yearly causing potential harm to all the patients being seen by the therapist. (P)</p> <p>Findings:</p> <p>1. Personnel record P, date of hire 10/23/08, failed to evidence a completed "Questionnaire for Positive TB Skin Test Reactions" in 2010. The last completed questionnaire was 7/15/09. The employee left the agency 9/8/11.</p> <p>2. December 8, 2011, at 3 PM, employee CC indicated the questionnaire had not been completed.</p>	N0464	<p>100% of personnel files have been audited, 20% of personnel files or minimum of 10 records will continue to be audited for TB, Home Health Aide certification, Limited Criminal History, Performance Evaluations, Job descriptions, and qualifications quarterly for Performance Improvement. Audits to be performed by HR Supervisor. Administrator/DON will audit 100% of all new personnel files before first patient contact. To ensure Indiana State-Federal requirements are met. New orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/Nurses Review P&amp;P: 1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care Plan/Documentation 10. Client Admission 11. Oasis Policy 12. Plan of Care 13. Medical Supervisor 14. In-services 15.</p>	12/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesChart Audit with reviewSelf Skills CheckOn site visit with Clinical Coordinator/DON/Alternate DON x2 within 30 daysPsuedo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific)Non-professionals:Will be skills checked by contracted qualified RNCompetency testedAnnual evaluations to be performed on site by employees of CJs Abundant Care Clinical Coordinator/DON/Administrator. Utilizing new process: The employee anniversary date will be tracked in Software and pulled previous month to perform evaluations for upcoming month.100% of Home Health Aides where given an annual performance re-evaluation by Clinical Coordinator/DON 100% of New Personnel orientation will be reviewed by Administrator/Alternate Administrator/DON/Alternate DON to ensure compliance of new orientation process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0472	<p>Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on document review, policy review, and interview, the agency failed to ensure the ongoing quality assurance program was designed to objectively and systematically monitored and evaluated the quality and appropriateness of patient care, resolved identified problems, and improved patient care.</p> <p>Findings include:</p> <p>1. The agency policy titled "Clinical Record Review" approval date 1/28/11 states, "A clinical record review will be conducted to determine the extent to which CJ ' s Abundant Care staff complies with accepted professional standards and principles, federal and state regulations, and accreditation standards. This review will be completed by representatives of appropriate health care disciplines. ... Purpose: To evaluate</p>	N0472	To ensure compliance:Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON.Recert audits to be performed at end of each 60 day episode by Clinical Coordinator	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>appropriate admission and discharge. To evaluate the appropriateness, adequacy and effectiveness of services. To identify over - under utilization of services. To identify gaps in agency service, and need for in-service education, staffing, consulting services, and agency policies. To ensure records reflect care and / or service provided, the client ' s current condition, and the client ' s progress towards goals and condition at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plan s of care. To evaluate adverse outcome reports and identify documentation limitations or the need for focused plan to improve client outcomes through targeted interventions. Special Instructions: The Clinical Record Review Committee is a subcommittee of the Professional Advisory Committee. ... The responsibility for the review program is primarily assigned to the Director of Nursing / designee. The committee is responsible for client care evaluation. ... The committee shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. ... The committee shall make recommendations about specific client documentation issues to the administrator to review. ... The</p>		<p>and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON and reviewed by Administrator/Alternate Administrator. In-serviced SN of following policies and procedures:1. Wound Care2. Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6. Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing Services Physician Verbal Order form changed to include VO date and time on 12/9/2011 Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care. To ensure compliance by weekly case conference. Policy revision of Physicians Orders completed. All SN providing care are to receive copy of Plan of Care Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Committee shall routinely examine the findings of the previous reviews to determine focus and assure quality client care." The agency documents failed to evidence the agency had completed quarterly chart audits per agency policy since June 17, 2011.</p> <p>2. The policy titled "Performance Improvement" states, "Purpose: To improve client and agency outcomes through a coordinated collaborative approach to assessing and improving organizational structure. ... To identify deviations from CJ's and professional standards and pursue improvement opportunities by assessment, planning and evaluation. ... To reduce factors that contribute to unanticipated adverse events and / or outcomes. ... Activities for performance improvement will be the responsibility of the Administrator. Program will reflect participation by all services and all levels of staff. Data will be collected to allow the agency to monitor its performance. ... Data will be systematically collected to measure process and outcome. ... Intensive assessment will be completed when undesirable patterns or trends in performance is detected or important sentinel events are identified. The plan will target the performance of existing processes and outcomes and identify /</p>		<p>Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. .Original assessments will be filed in patients chart after data entry and locking by Data entry employee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>design new processes based on priorities, standards, and resources."</p> <p>3. On December 7, 2011, at 1:45 PM, employee F indicated the extent of the clinical record review and quality assurance and improvement program available was presented for review to the surveyors and the physical therapist who was to have developed a fall prevention program had left the agency and the agency management had yet to develop and implement a program.</p> <p>4. Eleven documents titled "Audit Tool" were presented as evidence of the agency's clinical record review ending with the 3rd quarter in September of 2011. Each of the 11 Audit Tools contained a patient's name and a list of items the auditor was to determine if the record had met compliance. Only 2 of the Audit Tools completed included the name of the auditor; 8 of the Audit Tools failed to identify the Recertification period in review; 5 of the Audit Tools failed to identify the date the audit was completed.</p> <p>A. One of the undated "Audit Tools" states, "485 (5/21 to 7/19/11) had diagnosis of pressure ulcer heel. She doesn't have area on heel." In another area of the same audit states, "No skilled nurse ordered."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>B. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 2nd indicates that a total of 16 clinical records were reviewed. The agency failed to evidence the 16 clinical record reviews that were completed.</p> <p>C. The document titled "Clinical Record Review Results" dated as 2011 Quarter 2nd indicates the agency's census was 112 for the quarter and stated, "Items not filled out in 7 charts, patient response to teaching, coordination of care, discharge planning, aide supervision, vital signs, no orders for the Recertification. Other findings: frequency off, discharge summary not done, 60 day summary not done, wrong diagnosis, diagnosis does not match the 485, patient signatures and orders not back."</p> <p>D. The document titled "PI Minutes" states, "2 nd Quarter 2011 ... 7/14/11 ... Infection Report 26 patient infections ... Trends - 16 UTI (urinary tract infections) Action - In service aides on proper peri / cath care due to 11 /16 have anchored cathes. ... Occurrence Reports: 12 Patient reports ... 10 falls with 5 witnessed and 2 resulted in an ER visit Trends None. Action - Continue to Monitor and report. Therapist to continue with developing a fall prevention</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>program. ... 12 Total complaints received, ... Trends none ... Adverse Events: Did have findings of 4 incidents, Trends - falls 3 with ER visit, 1 admitted. Action - Continue with PT for fall prevention Program." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>E. The document titled "Clinical Record Review Roster" dated as 2011 Quarter 3rd indicates that a total of 15 clinical records were reviewed. The agency failed to evidence the 15 clinical record reviews.</p> <p>F. The document titled "Clinical Record Review Results" dated as 2011 Quarter 3rd indicates the agency's census was 83 for the quarter states, "No trends, few orders unsigned, coordination of care, few frequencies don ' t match."</p> <p>I. The document titled "PI Minutes" states, "3 rd Quarter 2011 ... 11/11/11 ... Infection Report 21 patient infections ... 13 UTI (urinary tract infections) with only one having a urinary catheter. Mediport infection reported 4 times from same patient, Trends UTI Action - Review with nurses findings. Use insert for UTI high risk patients for education. ... Occurrence Reports: 20 Patient Occurrences ... All patient</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>occurrences were falls, 17 due to loss of balance, 3 other reasons, 2 resulted in hospital admissions, 1 to ER, others no significant injuries. Action - Once PT [physical therapy] in place to research falls and develop plan. Until then, staff to monitor home safety with patients. ... Complaint / Resolution 19 reported, 10 patients, 5 on aides that patient requested new aide, some they felt was not doing good job cleaning. 9 employees, 1 employee patient was doing illegal activity, No Trends, All issues were resolved, Cont to monitor.. ... Satisfaction Surveys ... 5 returned from non - skilled with showing 1 patient doesn't feel pain is managed." The document failed to evidence a written plan with interventions and measurable goals.</p> <p>5. On December 7, 2011, at 4 PM, employee F indicated she had not had contact with the Professional Advisory Committee (PAC) as most of the members of the PAC had left the agency. A new group was formed, but she had not had contact or meetings with the new PAC. There was not any evidence of a written ongoing agency plan or meeting meetings that document the plan for the administrative review as to how the agency was continually evaluating itself, and indicated there was no further documentation to evidence.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 policy review and interview, the agency failed to ensure the registered nurse and physician coordinated efforts in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor</p>	N0484	<p>To ensure compliance:Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate</p>	12/28/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no</p>		<p>DON and reviewed by Administrator/Alternate Administrator.In-serviced SN of following policies and procedures:1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care. To ensure compliance by weekly case conference. Policy revision of Physicians Orders completed. All SN providing care are to recieve copy of Plan of CarePhysicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax.Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.All original</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>3. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient</p>		<p>assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. .Original assessments will be filed in patients chart after data entry and locking by Data entry employee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>I. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin lt [left] foot location - left foot - duration -</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>P. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>Q. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>R. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>S. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>T. The record failed to evidence the patient's care was coordinated with the physician at any time.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0505	<p>Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:</p> <p>(2) The patient has the right to the following:</p> <p>(D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows:</p> <p>(ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following:</p> <p>(AA) The care or treatment. (BB) Changes in the care or treatment.</p> <p>Based on clinical record review and interview the agency failed to ensure the patient had been involved in the planning of care when the occupational therapist was terminated in 2 of 2 records reviewed of patients being seen by the occupational therapist. (7 and 8 )</p> <p>Findings:</p> <p>1. Clinical record 7, start of care 8/4/11, evidenced a plan of care for the certification period 8/4/11 to 10/2/11 with orders for Occupational Therapy services. The clinical record evidenced a "Discharge Summary/Order" dated 9/8/11 that states, "Effective 9/8/11, discharge Occupational therapy at this time due to termination of Occupational therapy employee. If you wish for patient to be transferred to another agency for Occupational therapy please fax order."</p>	N0505	<p>Administrator/DON implemented revised Discharge/Order Summary to ensure patient involved in any changes of the plan of care. Administrator/DON to review every Discharge/Order Summary form to ensure patient involved in any change in their plan of care. The form will include patient signature of choice to remain with agency or choose to transfer to provider that can provide the discharge discipline. Form will then be faxed to physician for order to ensure patients participation in care. In-serviced Clinical Coordinator and all nurses on implementation and purpose of form.</p>	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The clinical record failed to evidence the patient was notified or given the option of choosing another agency.</p> <p>December 8, 2011, at 11 AM, Employee F indicated the clinical record did not evidence the patient had been informed they had the right to choose a different agency in order to receive Occupational Therapy.</p> <p>2. Clinical Record # 8, start of care 8/4/11 evidenced a plan of care for the certification period 8/4/11 through 10/2/11 included an order for occupational therapy to evaluate and treat. The clinical record evidenced that the patient received occupational therapy through 8/26/11. The clinical record evidenced a document titled "Discharge / Summary Order" dated 9/8/11 which states, "D/C [discharge] OT [occupational therapy] effective 9/8/11 due to termination of OT. If you wish for patient to be transferred to another agency for OT, please fax order." The clinical record failed to evidence the patient was notified of the lack of occupational therapist available within the agency and given the option to change agencies or the choice of another agency.</p> <p>On 12/7/11 at 3:45 PM, employee F indicated there was no documentation to evidence the patient was given the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0522	<p>opportunity to participate in the plan of care, notified of the termination of the only occupational therapist available with the agency, and the opportunity to exercise the right to transfer to another agency that could provide OT.</p> <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: Based on clinical record and policy review and interview, the agency failed to ensure visits and treatments were provided as ordered on the plan of care and there were orders for all treatments in 6 of 7 clinical records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients. (4, 6, 7, 8, 9 and 10)</p> <p>Findings:</p> <p>1. Clinical record 4, SOC 10/27/11, evidenced a plan of care for the certification period 10/27/11 to 12/25/11 with orders for skilled nursing every other week for 9 weeks and home health aide services. The clinical record identified 3 skilled nurse visit during the first week (10/27/11), fourth week (11/17/11), and</p>	N0522	100% of active patients charts to be audited by Administrator/Clinical Coordinator/DON and any professional staff of last two certification periods by 1/5/2012 with Plan of action developed for findings with specific goal dates . Then Assigned audit sheets to appropriate health professionals each quarter with 10% of census ,( minimum 10) active/discharged being audited with review by DON/Alternate DON with Plan of Action developed with goals dates to address and act upon trends.Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON.Assignment of patients to	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>seventh week (12/8/11).</p> <p>A. The plan of care failed to evidence an order for homemaker services, but the clinical record identified the homemaker provided services 10/27/11, 11/1/11, 11/10/11, 11/15/11, and 11/21/11.</p> <p>B. On December 5, 2011, at 2:15 PM, Employee F indicated the skilled nursing visits were not as ordered and the homemaker services were not on the plan of care.</p> <p>2. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 10/5/11 to 12/3/11 with orders for skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement. The patient returned home 10/19/11 on Coumadin with home health care orders for "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record does not identify the physician was notified the family wished</p>		<p>SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON. Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care is assigned as evaluating SN has deemed upon SOC, and RECERT. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care. Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as warranted. In-serviced nursing staff on following Policies and Procedures</p> <p>1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders/Physician Notification 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care Plan/Documentation 10. Client Admission 11. Oasis Policy 12. Plan of Care 13. Medical Supervision 14. In-services 15. Pressure Ulcer Prevention 16. Pain Management 17. Skilled Nursing Services: and Braden Scale. Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>to discontinue to draw nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>3. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the certification period 10/3/11 to 12/1/11 with a physician order for every other week for medication set-up by the skilled nurse. The clinical record identified med set up occurred 10/18/11 and not again until 11/19/11.</p>		<p>and for high risk of skin breakdown for preventative measures. New orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/Nurses Review P&amp;P: 1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care Plan/Documentation 10. Client Admission 11. Oasis Policy 12. Plan of Care 13. Medical Supervision 14. In-services 15. Pressure Ulcer Prevention 16. Pain Management 17. Skilled Nursing Services Chart Audit with review Self Skills Check On site visit with Clinical Coordinator x2 within 30 days by Clinical Coordinator/DON/Alternate DON Suedo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>4. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient was able to get to and from the toilet, able to dress upper body without assistance if clothing was laid out or handed to the patient, and able to bear weight and pivot during the transfer process, but unable to transfer self. An unsigned recertification assessment dated 9/28/11 indicates the patient was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, and requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>A. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment."</p> <p>B. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit</p>		specific)All SN providing care are to recieve copy of Plan of Care		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>note failed to evidence the patient was assessed for pain.</p> <p>C. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence an order for ice or heat."</p> <p>F. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>G. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY 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 a physician in a timely manner."</p> <p>5. Clinical record 9, SOC 3/17/11, evidenced a plan of care for the certification period 9/13/11 to 11/11/11 with orders for skilled nursing 1 time a day, 7 days a week for 9 weeks for glucometer checks and insulin injection using a sliding scale. Blood sugar results between 141-180 were to receive 1 unit of insulin. The clinical record evidenced, on 10/21/11, a blood sugar of 145 with 0 insulin given, 10/25/11 a blood sugar of 151 with 0 insulin given, 11/1/11 a blood sugar of 155 with 0 insulin given, and on 11/4/11 a blood sugar of 161 with 0 insulin given. The clinical record failed to evidence a visit for 11/8/11.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0527	<p>6. Clinical record 10, SOC 4/25/10, evidenced a plan of care for the certification period 10/17/11 to 12/15/11 with orders for skilled nursing 1 time a day, 7 day a week, for 9 weeks for glucometer checks and insulin administration. The clinical record failed to evidence the skilled nurse made a visit 10/26/11.</p> <p>7. On December 8, 2011, at 10:30 AM, Employee F indicated the findings in the clinical record were correct.</p> <p>8. A policy dated 1/28/22 titled "Skilled Nursing Services", C-200, states "Skilled nursing services will be provided by a Registered nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders)."</p> <p>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.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>Based on clinical record and policy review and interview, the agency failed to ensure the physician was notified of changes in the patient's condition or changes that could affect the patient's condition in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the</p>	N0527	<p>To ensure compliance Skilled Nurses in-serviced on following policies and procedures:1. Wound Care2. Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6. Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conferences.. Policy revision of Physicians Orders completed. To ensure compliance SN staff in-serviced on following policies:In-serviced nursing staff on Braden Scale.Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures.In-serviced Home Health Aides on Scope of</p>	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the</p>		<p>Practice and When to notify supervisor. All SN providing care are to recieve copy of Plan of Care Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>2. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin lt [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>P. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>Q. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>R. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0532	<p>S. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>T. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. Based on clinical record and policy review and interview, the agency failed to ensure the physician was notified of changes in the patient's condition or changes that could affect the patient's condition in 2 of 2 clinical records reviewed of patients whose care resulted</p>	N0532	To ensure compliance Skilled Nurses in-serviced on following policies and procedures:1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8.	12/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient</p>		<p>Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conferences.. Policy revision of Physicians Orders completed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>2. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin lt [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>P. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>Q. On December 7, 2011 at 10:20 AM,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>R. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>S. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0534	<p>health and personal care services."</p> <p>T. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>Rule 13 Sec. 3(b) The personal services agency's manager or the manager's designee shall prepare a service plan for a client before providing personal services for the client. A permanent change to the service plan requires a written change to the service plan. The service plan must:</p> <p>(1) be in writing, dated, and signed by the individual who prepared it;</p> <p>(2) list the types and schedule of services to be provided; and</p> <p>(3) state that the services to be provided to the client are subject to the client's right to:</p> <p>(A) temporarily suspend;</p> <p>(B) permanently terminate;</p> <p>(C) temporarily add; or</p> <p>(D) permanently add;</p> <p>the provision of any service.</p> <p>Based on clinical record review and interview, the agency failed to ensure a service plan had been prepared for 5 of 7 records reviewed of patients needing personal services. (1, 2, 5, 7, and 10)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC)</p>	N0534	Assignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON. Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care/service is assigned as evaluating SN has deemed upon SOC, Resumption,	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
	<p>8/22/11, evidence a plan of care for the certification period 10/21/11 to 12/19/11 with orders for homemaker services. The "Homemaker Care Plan" dated 8/19/11 failed to evidence Frequency and Comments for assigned duties and facility signatures with Review Dates. The clinical record evidenced homemaker services were provided 10/21/11, 10/24/11-10/28/11, 10/31/11-11/4/11, 11/7/11-11/11/11, and 11/14/11-11/18/11.</p> <p>2. Clinical record 2, SOC 6/2/11, evidence a plan of care for the certification period 9/30/11 to 11/28/11 with orders for homemaker services. The "Homemaker Care Plan" dated 6/2/11 failed to evidence frequency and Comments for assigned duties and dates of review. The clinical record evidenced homemaker services were provided 10/3/11, 10/10/11, 10/17/11, 10/25/11, 10/31/11, 11/7/11, 11/15/11 and 11/21/11.</p> <p>3. Clinical record 5, SOC 2/5/09, evidence a plan of care for the certification period 9/23/11 to 11/21/11 with orders for attendant and homemaker services. The clinical record failed to evidence a "Homemaker Care Plan."</p> <p>4. Clinical record 7, SOC 8/4/11, evidence a plan of care for the certification period 10/3/11 to 12/1/11</p>		Recert and SCIC. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
N0537	<p>with orders for homemaker services. The "Homemaker Care Plan" dated 11/4/11 failed to evidence a Review Date and Signature of agency staff. The clinical record evidenced the homemaker provided services twenty-one times throughout the certification period.</p> <p>5. Clinical record 10, SOC 4/25/10, evidence a plan of care for the certification period 10/17/11 to 2/15/11 with a "HHA/Homemaker Careplan" dated 10/13/11. The homemaker services and home health aide services were combined on the same care plan without differentiating who was responsible for what activities. Nutrition services were not ordered. The clinical record evidenced the attendant provided nutritional services on 11/17/11 and 11/20/11.</p> <p>5. December 8, 2011, at 11 AM, Employee F indicated the Careplans were not correct.</p> <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: Based on clinical record and policy review and interview, the agency failed to ensure the skilled nurse provided visits and treatments as ordered on the plan of</p>	N0537	To ensure compliance Skilled Nurses in-serviced on following policies and procedures:1. Wound Care2.Ostomy Care3.	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>care and there were orders for all treatments in 6 of 7 clinical records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients. (4, 6, 7, 8, 9 and 10)</p> <p>Findings:</p> <p>1. Clinical record 4, SOC 10/27/11, evidenced a plan of care for the certification period 10/27/11 to 12/25/11 with orders for skilled nursing every other week for 9 weeks and home health aide services. The clinical record identified 3 skilled nurse visit during the first week (10/27/11), fourth week (11/17/11), and seventh week (12/8/11).</p> <p>On December 5, 2011, at 2:15 PM, Employee F indicated the skilled nursing visits were not as ordered on the plan of care.</p> <p>2. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 10/5/11 to 12/3/11 with orders for skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement. The patient returned home 10/19/11 on Coumadin with home health care orders for "PT/INR on 10/25/11 and 10/27/11,</p>		<p>Documentation4. Case Conference/Coordination of Care5. V/S6. Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conferences.. Policy revision of Physicians Orders completed. In-serviced SN of following policies and procedures:1. Wound Care2. Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6. Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record does not identify the physician was notified the family wished to discontinue to draw nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>3. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the certification period 10/3/11 to 12/1/11 with a physician order for every other week for medication set-up by the skilled nurse. The clinical record identified med set up occurred 10/18/11 and not again until 11/19/11.</p> <p>4. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient was able to get to and from the toilet, able to dress upper body without assistance if clothing was laid out or handed to the patient, and able to bear weight and pivot during the transfer process, but unable to transfer self. An unsigned recertification</p>		<p>VO date and time on 12/9/2011 Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conferences. Policy revision of Physicians Orders completed. All SN providing care are to receive copy of Plan of Care Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance. Assignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON. Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care/service is assigned as evaluating SN has deemed upon SOC, Resumption, Recert and SCIC. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care. Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as warranted. In-serviced nursing staff on Pain Management,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>assessment dated 9/28/11 indicates the patient was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, and requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>A. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment."</p> <p>B. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>C. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p>		<p>and Braden Scale. Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures. In-service staff on: Skilled Nursing Services/Physician Orders/Physician Notification: Compliance manual implemented to match visit frequency against orders to ensure visits made as per Plan of Care by Clinical Coordinator/Nursing Scheduler. All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. After data entry and locking Original assessments will be filed in patients chart by data entry employee. Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/Administrator/DON/Alternate DON to review log book weekly to ensure compliance. Assignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON. Clinical</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
	<p>D. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence an order for ice or heat."</p> <p>F. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>G. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services</p>		<p>Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care is assigned as evaluating SN has deemed upon SOC, Resumption, Recert and SCIC. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care.Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as warranted.In-serviced nursing staff on Pain Management, and Braden Scale.Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures.:Compliance manual implemented to match visit frequency against orders to ensure visits made as per Plan of Care by Clinical Coordinator/Nursing Scheduler</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>provided to clients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by a physician in a timely manner."</p> <p>5. Clinical record 9, SOC 3/17/11, evidenced a plan of care for the certification period 9/13/11 to 11/11/11 with orders for skilled nursing 1 time a day, 7 days a week for 9 weeks for glucometer checks and insulin injection using a sliding scale. Blood sugar results between 141-180 were to receive 1 unit of insulin. The clinical record evidenced, on 10/21/11, a blood sugar of 145 with 0 insulin given, 10/25/11 a blood sugar of 151 with 0 insulin given, 11/1/11 a blood sugar of 155 with 0 insulin given, and on 11/4/11 a blood sugar of 161 with 0 insulin given. The clinical record failed to evidence a visit for 11/8/11.</p> <p>6. Clinical record 10, SOC 4/25/10, evidenced a plan of care for the certification period 10/17/11 to 12/15/11 with orders for skilled nursing 1 time a day, 7 day a week, for 9 weeks for glucometer checks and insulin administration. The clinical record failed to evidence the skilled nurse made a visit 10/26/11.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
N0540	<p>7. On December 8, 2011, at 10:30 AM, Employee F indicated the findings in the clinical record were correct.</p> <p>8. A policy dated 1/28/22 titled "Skilled Nursing Services", C-200, states "Skilled nursing services will be provided by a Registered nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders)."</p> <p>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 review and interview, the agency failed to ensure the registered nurse did the initial evaluation in 3 of 3 clinical records reviewed of patients with skilled services since the recertification survey 7/11 with the potential to affect all new patients of the agency. (4, 6, and 7)</p> <p>Findings:</p> <p>1. Clinical record 4, start of care (SOC) 10/27/11, evidenced a plan of care for the</p>	N0540	To ensure compliance Skilled Nurses in-serviced on following policies and procedures:1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>certification period 10/27/11 to 12/25/11 with orders for skilled nursing and home health aide services. The clinical record failed to evidence an initial assessment by the registered nurse.</p> <p>2. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 10/5/11-12/3/11 with orders for skilled nursing, home health aide, and physical therapy services. The clinical record failed to evidence an initial assessment by the registered nurse.</p> <p>3. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the certification period 8/4/11 to 10/2/11 with orders for skilled nursing, home health aide, occupational therapy, physical therapy, attendant care and homemaker services. The clinical record failed to evidence a initial assessment by the registered nurse.</p> <p>4. December 5, 2011, at 12 PM, the Clinical Coordinator Employee E indicated all assessment forms had been shredded and the only forms available were computer generated Oasis forms.</p>		<p>Nursing Services Physician Verbal Order form changed to include VO date and time on 12/9/2011 Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care. with weekly case conference. Policy revision of Physicians Orders completed. All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. Original assessments will be filed in patients chart. Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/Administrator/DON/Alternate DON to review log book weekly to ensure compliance. Assignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON. Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care is assigned as evaluating SN has deemed upon SOC, Resumption, Recert and SCIC. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0541	<p>Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse reevaluated the patient's needs after a significant change condition in 1 of 1 record reviewed of patients with a significant change in condition (#8) and completed a recertification comprehensive assessment in 5 of 5 clinical records reviewed of patients receiving services over 60 days</p>	N0541	<p>with copy to SN assigned to care.Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as warranted.In-serviced nursing staff on Pain Management, and Braden Scale.Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures.:Compliance manual implemented to match visit frequency against orders to ensure visits made as per Plan of Care by Clinical Coordinator/Nursing Scheduler</p> <p>To ensure compliance Skilled Nurses in-serviced on following policies and procedures:1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12.</p>	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>with the potential to affect all the agency's patients who receive services longer than 60 days. (#6, 7, 8, 9 and 10)</p> <p>Findings:</p> <p>1. Clinical Record # 8, start of care 8/4/11, evidenced a plan of care for the certification period 10/3/11 through 12/1/11 with orders for the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The clinical record evidenced a skilled nurse visit note dated 10/31/11 at 4 PM, written by employee I, that states, "Client seized for about 5 minutes, ... medics alerted, ... transferred per ambulance to hospital." The clinical record failed to evidence a visit note or a missed visit notification for 11/1/11. The clinical record evidenced a skilled nurse visit note dated 11/2/11 written by employee I which indicates the patient was home on 11/2/11. The clinical record failed to evidence an other follow up assessment was completed when the patient returned home from the seizure episode.</p> <p>On December 7, 2011, at 4:05 PM, employee F indicated there was not a reassessment of the patient upon return from the seizure episode nor was there sufficient documentation in the clinical record to know when the patient returned</p>		<p>Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care. with weekly case conference. Policy revision of Physicians Orders completed. All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. Original assessments will be filed in patients chart.Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/Administrator/DON/Alternate DON to review log book weekly to ensure compliance.Assignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON.Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care is assigned as evaluating SN has deemed upon</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>home from the hospital, the condition of the patient upon return, or what treatment the patient received.</p> <p>2. Clinical record 6, SOC 10/5/11, evidenced a plan of care for the certification period 12/4/11 to 2/2/12 with orders for skilled nursing, home health aide, and physical therapy. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment.</p> <p>3. Clinical record 7, SOC 8/4/11, evidenced a plan of care for the certification period 10/3/11 to 12/1/11 with orders for skilled nursing, home health aide, physical therapy, attendant care, and homemaker. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment.</p> <p>4. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned start of care assessment dated 8/4/11. The recertification assessment dated 9/28/11 was also unsigned.</p> <p>5. Clinical record 9, SOC 3/17/11, evidenced a plan of care for the certification periods 7/15/11 to 9/12/11, 9/13/11 to 11/11/11, and 11/12/11 to 1/10/12. The clinical record failed to</p>		<p>SOC, Resumption, Recert and SCIC. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care.Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as warranted.In-serviced nursing staff on Pain Management, and Braden Scale.Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures.:Compliance manual implemented to match visit frequency against orders to ensure visits made as per Plan of Care by Clinical Coordinator/Nursing SchedulerAssignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON.Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care is assigned as evaluating SN has deemed upon SOC, and RECERT. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care.Scheduling to be monitored by Nursing Scheduler for Missed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>evidence the registered nurse had completed a recertification comprehensive assessment for the certification periods identified.</p> <p>6. Clinical record 10, SOC 4/25/10, evidenced a plan of care for the certification periods 8/18/11 to 10/16/11 and 10/17/11 to 12/15/11. The clinical record failed to evidence the registered nurse had completed a recertification comprehensive assessment for the certification periods identified.</p> <p>7. December 5, 2011, at 12 PM, the Clinical Coordinator, Employee E, indicated all assessment forms had been shredded and the only forms available were computer generated Oasis forms.</p> <p>8. A policy approved 1/28/11 "Client Reassessment/Update of Comprehensive Assessment" C-155 states, "The Comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status. ... Reassessments must be done at least: 1. Every second calendar month beginning with start of care (within last 5 days of the episode, including day 60), 2. Within 48 hours of (or knowledge of) client return home from hospital admission of more than 24 hours for any reason other than</p>		<p>Visits, or Re-assignment of SN for Missed Visits as warranted. In-serviced nursing staff on following Policies and Procedures Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures. New orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/Nurses Review P&amp;P: 1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care Plan/Documentation 10. Client Admission 11. Oasis Policy 12. Plan of Care 13. Medical Supervision 14. In-services 15. Pressure Ulcer Prevention 16. Pain Management 17. Skilled Nursing Services Chart Audit with review Self Skills Check On site visit with Clinical Coordinator x2 within 30 days by Clinical Coordinator/DON/Alternate DON Pseudo patient visit with Clinical Coordinator/DON/Alternate</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0542	<p>diagnostic testing or other changes representing a SCIC (Significant Change in Condition). 3. Within 48 hours of (or knowledge of) discharge or transfer."</p> <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. Based on clinical record and policy review, observation, and interview, the agency failed to ensure the registered nurse initiated revisions in to the plan of care in 1 of 2 records reviewed of patients who experienced harm with the potential to affect all the agency's patients. (#8)</p> <p>Findings:</p> <p>1. 2. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis,</p>	N0542	<p>DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific)All SN providing care are to receive copy of Plan of Care</p> <p>To ensure compliance SN staff in-serviced on following policies:In-serviced nursing staff on Braden Scale.Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures.Skilled Nursing in-serviced on following Policies and Procedures:1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of</p>	12/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times</p>		<p>Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate carewith weekly case conferences. Policy revision of Physicians Orders completed. Assignment of patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON.Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care/service is assigned as evaluating SN has deemed upon SOC, Resumption, Recert and SCIC. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care.Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities</p>		<p>warranted.In-serviced nursing staff on Pain Management, and Braden Scale.Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures.In-service staff on: Skilled Nursing ServicesPhysician Orders/Physician Notification:Compliance manual implemented to match visit frequency against orders to ensure visits made as per Plan of Care by Clinical Coordinator/Nursing SchedulerIn-serviced Home Health Aides on Scope of Practice and When to notify supervisor.All original assessments will be turned into Clinical Coordinator/DON/Alternate DON to be reviewed and Data entered. Original assessments will be filed in patients chart.Physicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/Administrator/DON/Alternate DON to review log book weekly to ensure compliance.Assignment of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up		patients to SN staff will have Plan of Care reviewed with SN by Clinical Coordinator/DON/Alternate DON.Clinical Coordinator/DON/Alternate DON will review Plan of Care to ensure all disciplines are included, and appropriate care is assigned as evaluating SN has deemed upon SOC, Resumption, Recert and SCIC. Plan of Care will be signed by Clinical Coordinator/DON/Alternate DON with copy to SN assigned to care.Scheduling to be monitored by Nursing Scheduler for Missed Visits, or Re-assignment of SN for Missed Visits as warranted.In-serviced nursing staff on Pain Management, and Braden Scale.Braden Scale and Pain assessment to be performed at SOC, Recert, and Resumption of Care. Also as indicated in change of condition. With Physician notification for poor pain management per evaluations and for high risk of skin breakdown for preventative measures.:Compliance manual implemented to match visit frequency against orders to ensure visits made as per Plan of Care by Clinical Coordinator/Nursing Scheduler		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound." The record failed to evidence a revision to the plan of care to address the bedbound status.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
	<p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence a revision to the plan of care to address the patient's increased pain and an order for ice or heat.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin lt [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat.</p> <p>I. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>failed to evidence a revision to the plan of care to address the patient's increased lack of a caregiver on a regular basis.</p> <p>J. On December 7, 2011, at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>2. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>3. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>4. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>6. The policy titled "Client Reassessment / Update of the Comprehensive Assessment" states, The comprehensive assessment will be updated and revised as often as the clients condition warrants due to a major decline ... Within 48 hours of or knowledge of client return from a hospital admission of more than 24 hours, ... or other changes representing a SCIC (significant change in condition). PURPOSE To identify decline or improvement in health status, modify the plan of care and document changes that may affect care and reimbursement."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0543	<p>Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse initiated preventative nursing procedures to prevent patient harm in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state</p>	N0543	<p>To ensure compliance:Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON and reviewed by Administrator/Alternate Administrator In-serviced SN of following policies and</p>	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p>		<p>procedures:1. Wound Care .2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conference. To ensure compliance by onsite weekly case conference. Policy revision of Physicians Orders completed. All SN providing care are to recieve copy of Plan of CarePhysicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.All original assessments will be turned into Clinical Coordinator/DON/Alternate</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>3. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic</p>		<p>DON for review and Data entered. Original assessments will be filed in patients chart once data entried and locked by Data entry employee.New orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/NursesReview P&amp;P: 1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervison14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesChart Audit with reviewSelf Skills CheckOn site visit with Clinical Coordinator x2 within 30 days by Clinical Coordinator/DON/Alternate DONPsuedo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular</p>		<p>d. Ostomy Care e. Other procedures as they arise (patient specific)Non-professionals:Will be skills checked by contracted qualified RNCompetency testedAnnual evaluations to be performed on site by employees of CJs Abundant Care Clinical Coordinator/DON/Administrator on employee anniversary date as tracked in Software and pulled previous month to perform evaluations for upcoming month.100% of Home Health Aides where given an annual performance re-evaluation by Clinical Coordinator/DON</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(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
	<p>employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin lt [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ...</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note"</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>P. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>Q. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>R. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0545	<p>weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>S. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>T. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>U. The record failed to evidence the patient's care was coordinated with the physician at any time.</p> <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>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse coordinated services with the physician to prevent patient harm in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the</p>	N0545	<p>To ensure compliance:Performance Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON.Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON and reviewed by Administrator/Alternate Administrator In-serviced SN of following policies and procedures:1. Wound Care .2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders/Physician Notification7. Performance Improvement8.</p>	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>consequences of discontinuing the draw. The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal</p>		<p>Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conference. To ensure compliance by onsite weekly case conference. Policy revision of Physicians Orders completed. All SN providing care are to recieve copy of Plan of CarePhysicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.All original assessments will be turned into Clinical Coordinator/DON/Alternate DON for review and Data entered. Original assessments will be filed in patients chart once data entried and locked by Data entry employee.New orientation processes implemented for all Professional and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>orders may be taken by licensed personnel designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>3. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able</p>		<p>non-professional staff. In-serviced Clinical Coordinator and implemented Orientation processes. Processes to include for Therapist/NursesReview P&amp;P: 1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesChart Audit with reviewSelf Skills CheckOn site visit with Clinical Coordinator x2 within 30 days by Clinical Coordinator/DON/Alternate DONPsuedo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific)Non-professionals:Will be skills checked by contracted qualified RNCompetency testedAnnual evaluations to be performed on site by employees</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>to dress upper body without assistance if clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other</p>		<p>of CJs Abundant Care Clinical Coordinator/DON/Administrator on employee anniversary date as tracked in Software and pulled previous month to perform evaluations for upcoming month. 100% of Home Health Aides where given an annual performance re-evaluation by Clinical Coordinator/DON</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
	<p>ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>leg, and a plan of care for the increased immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>document titled "Nursing Visit Note" dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin lt [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>L. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>P. The clinical record evidenced a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>document titled "Nursing Visit Note" dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>Q. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>R. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>S. Agency policy #C-580, not dated,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0546	<p>titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>T. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>U. The record failed to evidence the patient's care was coordinated with the physician at any time.</p> <p>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</p>	N0546	To ensure compliance:Performance	01/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>review and interview, the agency failed to ensure the physician was notified of changes in the patient's condition or changes that could affect the patient's condition in 2 of 2 clinical records reviewed of patients whose care resulted in patient harm with the potential to affect all the agency's patients. (#6 and 8)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 10/5/11, evidenced a plan of care for 10/5/11 to 12/3/11 with skilled nursing, home health aide, and physical therapy. The clinical record identified the patient was transferred to the hospital on 10/13/11 for a scheduled left knee replacement and returned home 10/19/11 on Coumadin with home health care orders that state, "PT/INR on 10/25/11 and 10/27/11, then every Monday and Thursday until discontinued." A "Physician Verbal Order" that is unsigned by the Supervisor and the Physician and does not have a fax date nor a repeat verify date and time states, "Per patient and family - they state to discontinue PT/INR draws." The clinical record failed to evidence the physician was notified the family wished to discontinue the draw to coordinate the patient's care nor does it indicate the family was educated about the consequences of discontinuing the draw.</p>		<p>Improvement committee assigned. Plan of action form in place to be completed with each quarterly PI by DON/Alternate DON. POA form will have goal date. POA form will be reviewed by Administrator. Audit form revised to include patient name, auditors name/title and certification period being audited. 100% of nursing notes will be audited to 485 weekly for 6 months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON. Recert audits to be performed at end of each 60 day episode by Clinical Coordinator and filed on site. Any trends shall be placed on Plan of Action form with goal dates by DON/Alternate DON and reviewed by Administrator/Alternate Administrator In-serviced SN of following policies and procedures: 1. Wound Care 2. Ostomy Care 3. Documentation 4. Case Conference/Coordination of Care 5. V/S 6. Physician Orders/Physician Notification 7. Performance Improvement 8. Clinical Record Review 9. HHA Supervisory/Care</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The skilled nurse did not make a nursing visit after 10/27/11 until the resumption of care on 11/16/11.</p> <p>A. "Centricity Clinical Information" dated 11/12/2011 indicates the patient was airlifted from St. John's hospital in Anderson to Indiana Heart Hospital in Indianapolis. "Blood pressure on arrival was 77/51 mmHg with a pulse of 125 beats per minute that was irregular. The patient was given fluid bolus. The patient had some mild epigastric discomfort and some problems with nausea and vomiting over the last day or two. The prompted a CAT scan ... witch showed a large pericardial effusion. The patient is on Coumadin anticoagulation therapy. A stat INR came back elevated at 5.4. The patient remained hypotensive despite IV fluids and was tachycardia."</p> <p>B. On December 8, 2011, at 11:20 AM, Employee F indicated there was no indication the physician had been notified of the family wanting to change the PT/INR draw.</p> <p>C. A policy titled "Physician Orders", dated 1/28/11, C-635 states, "The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel</p>		<p>Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesPhysician Verbal Order form changed to include VO date and time on 12/9/2011Clinical Coordinator/DON/Alternate DON/Administrator to co-sign all Physician Orders and Notifications and coordinate care with weekly case conference. To ensure compliance by onsite weekly case conference. Policy revision of Physicians Orders completed. All SN providing care are to recieve copy of Plan of CarePhysicians orders will have attached confirmation fax sheet. A log book is in place and all orders not returned within 7 days will be refaxed followed by phone notification of returned fax. Clinical Coordinator/DON/Alternate DON to review log book weekly to ensure compliance.All original assessments will be turned into Clinical Coordinator/DON/Alternate DON for review and Data entered. Original assessments will be filed in patients chart once data entried and locked by Data entry employee.New orientation processes implemented for all Professional and non-professional staff. In-serviced Clinical Coordinator</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>designated by the agency in accordance with applicable le State and federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. ... 4. When agency staff obtain verbal/telephone orders from the physician, they must inform the supervising nurse/therapist of the change. The registered nurse or therapist responsible for furnishing or supervising the ordered service will co-sign the telephone order form before it is sent tot he physician. Orders can be initiated once the supervising nurse/therapist has been notified. ... 8. The nurse or therapist shall document implementation of order changes and instructions given to clients."</p> <p>2. Clinical Record # 8, start of care 8/4/11, evidenced an unsigned assessment dated 8/4/11 that indicated the patient with diagnosis of Multiple Sclerosis, chronic obstructive pulmonary disease, seizures, chronic pain, had a suprapubic catheter, a Braden score of 18, and was determined to be at risk of developing pressure ulcers. The patient was 6 feet tall, weighed 328 pounds, had 1 - 3 episodes of bowel incontinence weekly, was able to get to and from the toilet, able to dress upper body without assistance if</p>		<p>and implemented Orientation processes. Processes to include for Therapist/NursesReview P&amp;P: 1. Wound Care2.Ostomy Care3. Documentation4. Case Conference/Coordination of Care5. V/S6.Physician Orders7. Performance Improvement8. Clinical Record Review9. HHA Supervisory/Care Plan/Documentation10. Client Admission11. Oasis Policy12. Plan of Care13. Medical Supervision14. In-services15. Pressure Ulcer Prevention16. Pain Management17. Skilled Nursing ServicesChart Audit with reviewSelf Skills CheckOn site visit with Clinical Coordinator x2 within 30 days by Clinical Coordinator/DON/Alternate DONPsuedo patient visit with Clinical Coordinator/DON/Alternate DON utilizing OASIS/Comprehensive Assessment Procedures to be competency checked off for SN: By Clinical Coordinator/DON/Alternate DON as procedure arises: a. Venipunctures b. Catheterization c. Wound Care d. Ostomy Care e. Other procedures as they arise (patient specific)Non-professionals:Will be skills checked by contracted qualified RNCompetency testedAnnual evaluations to be performed on site by employees of C.Js Abundant Care Clinical Coordinator/DON/Administrator</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>clothing is laid out or handed to the patient, and was able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>A. An unsigned recertification assessment dated 9/28/11 indicates the patient experienced pain all the time with movement and ambulation, a "popped blister - pink bed" on buttocks with serosanguinous drainage, was able to bear weight and pivot during the transfer process but unable to transfer self, unable to get to and from the toilet but is able to use a bedside commode, requires a 2 handed device (walker or crutches) to walk alone or requires human assistance.</p> <p>B. The plan of care for the certification period 10/3/11 through 12/1/11 identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living],</p>		<p>on employee anniversary date as tracked in Software and pulled previous month to perform evaluations for upcoming month. 100% of Home Health Aides where given an annual performance re-evaluation by Clinical Coordinator/DON</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>C. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed, had a cast on the right ankle and foot, and the left leg and foot was rotated left and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital and examined in the emergency room. She was informed the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago." The patient indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers, and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient has not been routinely out of bed, except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated that the patient had been developing open areas since the first foot was fractured and applied to the patient's open skin areas on the left buttock "Moisture Barrier Fungal Cream." The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>D. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F. The record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>immobility.</p> <p>E. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/14/11 at 0800 that states, "SN assess completed. Pt [patient] BP [blood pressure] increased than normal for patient. Patient states she is having increased pain related to injury to left foot that occurred at MD [medical doctor] appointment today. Patient left foot became caught under wheel on electric wheelchair. Patient seen in hospital left foot wrapped and placed in boot, patient instructed to take pain medication as needed."</p> <p>F. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/15/11 that states, "Unable to leave home now, ... right cast left ace wrap ... bedbound.</p> <p>G. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/16/11 at 1130 that states, "Reason for visit ... Wound dressing change ... soiled wound dressing removed and wound care performed." The visit note failed to evidence the patient was assessed for pain.</p> <p>H. The clinical record evidenced a document titled "Nursing Visit Note"</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dated 11/17/11 at 1100 that states, "Reason for visit ... Wound dressing change ... wound cleaned." The visit note failed to evidence the patient was assessed for pain.</p> <p>J. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/18/11 that states, "Reason for visit ... Wd [wound] care ... pain - worse origin Lt [left] foot location - left foot. ... old dressing removed ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>K. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/19/11 that states, "Reason for visit ... Wd care ... pain - same origin Lt [left] foot location - left foot - duration - constant - Intensity 8-10 relief measures pain med heat - ice. wd care done ... small amount green brown drainage ... Instructed of ice / heat therapy for left foot." The clinical record failed to evidence the physician was contacted regarding the increased pain and failed to evidence an order for ice or heat."</p> <p>L. The clinical record evidenced a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>document titled "Nursing Visit Note" dated 11/21/11 that states, "Reason for visit ... Wd care ... pain - same. ... wd care done ... small amount green brown drainage. ... Has no family able to assist on a regular basis." The clinical record failed to evidence the physician was contacted regarding the increased pain, and failed to identify who was the primary caregiver in the home between the visits from the home health agency.</p> <p>M. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/22/11 that states, "Reason for visit ... Wd care ... pain - same ... old dressing removed ... small amount green brown drainage to old dressing."</p> <p>N. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/23/11 that states, "Reason for visit ... Wd care ... pain - none. ... wd care performed."</p> <p>O. The clinical record evidenced a document titled "Nursing Visit Note" dated 11/26/11 that states, "Reason for visit ... Wd care ... pain - same. ... minimum amount of small amount green brown drainage noted to old dressing."</p> <p>P. The clinical record evidenced a document titled "Nursing Visit Note"</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dated 11/27/11 that states, "Reason for visit ... Wd care ... pain - same. ... Small amount of small amount red brown drainage noted to old dressing."</p> <p>Q. On December 7, 2011 at 10:20 AM, employee I indicated that she completed the reassessment for the patient # 8 and that she did not know what the plan of care was to prevent the patients skin from breaking down, and that she had not contacted the hospital or physician that treated the patient after the injury to the left lower leg.</p> <p>R. The policy titled "Management / Prevention of Pressure Ulcers" states, "Prevention is the key to the management of pressure ulcers. Risk factor reduction must be a component of managing and treating existing ulcers and preventing them whenever possible. ... Identifying Risk Factors and Implementing Prevention Measures ... Turn and reposition every two hours. ... Range of Motion exercises. Lift rather than side body or part. Avoid positions with direct weight on bony prominence. ... Avoid increased pressure. Individualize bathing routines - Use pressure reducing devices."</p> <p>S. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
N0550	<p>Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."</p> <p>T. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."</p> <p>Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse updated the home health aide assignment as the patient's needs changed and mobility decreased for 1 of 9 clinical records reviewed of patients receiving home health aide services. (# 8)</p> <p>Findings include:</p>	N0550	To ensure compliance: 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON.To ensure compliance, purchased new Home Health Aide care plans and Home Health Aide notes that coorelate with	12/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>1. Clinical Record # 8, start of care 8/4/11, evidenced a plan of care for the certification period 10/3/11 through 12/1/11 that identified the skilled nurse (SN) was to visit once a day, seven days a week for 9 weeks. The plan of care states, "SN to evaluate all aspects of pain and treatment. ... Physical therapy 1 - 3 times a week for 9 weeks for gait training, therapeutic exercises, neuromuscular re-education, home exercise program, and safety awareness. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living], assistance with nutrition, light housekeeping duties, as assigned ... attendant care 1 - 5 hours a day, 1 - 5 times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, assist with other ADL's assist with nutrition. light housekeeping duties as assigned. HMK [homemaking] 1 - 3 hours per day, 1 - 3 times a week for 9 weeks for assistance with homemaking activities."</p> <p>A. During a home visit on December 6, 2011, at 12 PM, to the home of patient #8, the patient was observed in a hospital bed with a cast on the right ankle and foot and the left leg and foot was rotated left</p>		care plan.Inserviced 100% of Nurses and Home Health Aides on new documents and proper documentation on forms to match Plan of Care.Inserviced 100% of nurses on 12/22/2011 on policy/Regulation of Home Health Aide supervisory and Home Health needing to be observed providing personal care every 30 days. Aide Supervision form revised to ensure aide present with aide/patient signing form and with observation of personal care being performed every 30 days.Home Health Aide in-serviced on scope of practice and when to report to supervisor.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	and outward. The patient was observed to have no independent movement of the left leg. The patient required maximum assistance of the aide for bed mobility from a supine position to a left and right side lying position and then when returned back to the supine position. The patient was able to use bilateral upper extremities to aide in the bed mobility, but did not exhibit independent movement of the lower extremities. With assistance of the aide, the patient was able to bend the right knee slightly, the patient grimaced with any movement of the left leg and / or foot and when the aide touched the leg and foot to wash and dry during the bath. The patient verbalized experiencing severe pain in the left leg and foot with and without movement. The patient indicated the right ankle was fractured while transferring between surfaces at home in October and then the left foot was fractured and with injuries to the left lower leg in November while in an electric wheelchair. The patient indicated the foot pedal for the wheel chair had been removed, because of poor fit for the left leg, and that while propelling onto a mobile chair van at home for transport to a doctors appointment, the left leg was caught and pulled under the wheelchair. The patient indicated an agency aide was with the patient during the incident and the patient was then taken to the hospital				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	and examined in the emergency room and informed that the left foot was broken and that there were other injuries to the left lower leg and a soft cast was ordered to be worn. The patient stated, "They said to wear it when I am up." The patient indicated to understand the directions to wear the soft cast was to be worn when up out of bed, and then indicated that the last time the patient was out of bed was when the incident with the left leg occurred, and stated, "It happened about a month ago" and then indicated the soft cast had never been worn. The patient and caregiver indicated that up until the time the right ankle was broken, the patient was up ambulating with assistance of one and the use of a walker and was able to leave the bedroom. Then, after breaking the right ankle, the patient could still use the walker to assist with pivot transfers and use a bedside commode. The patient and caregiver indicated that since the left ankle was broken, the patient had not been routinely out of bed except for a doctors appointment. The surveyor observed the patient to have 2 open areas on the left buttock. Employee J indicated the patient had been developing open areas since the first foot was fractured. Employee J indicated the treatment and applied to the patient's open skin areas on the left buttock medication from the tube labeled "Moisture Barrier Fungal Cream."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The patient indicated the tube of ointment had been brought home from the rehabilitation unit in July.</p> <p>B. The clinical record evidenced a verbal order dated 11/29/11 and written by employee I that states, "Recertification for continuation of services provided by HHA [home health aide], PT [physical therapy], and SN [skilled nurse] for personal care needs." On 12/7/11 at 4:05 PM, the clinical record was reviewed with employee F, and the record failed to evidence a written medical plan of care that addressed the patients actual and potential health issues and risk factors, a plan to treat and prevent skin breakdown, a plan of care for the injured left lower leg, and a plan of care for the increased immobility.</p> <p>C. The "Home Health Aide Assignment Sheet /Plan of Care" dated 11/29/11 had a column titled "Activities" and, under the word ambulate, the patient's mode of mobility with a walker was part of the aide's assignment.</p> <p>D. On 12/6/11 at 12 PM, employee J indicated the patient was not ambulatory as both feet were broken. The assignment sheet failed to evidence it had been updated to reflect this change.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017			
(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			
N0597	<p>2. The policy titled "Home Health Aide Services" states, Services will be provided to appropriate clients ... under the direct supervision of an agency registered nurse / therapist in accordance with a medically approved plan of care. ... The aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising nurse. ... Delegated nursing tasks performed by home health aides must be properly delegated and documented according to specific state / federal and agency policies."</p> <p>3. The policy titled "Home Health Aide: Assignment states, "To provide direction and supervision of care provided by the home health aides. ... Any change in the assignment must be approved by the professional managing the client's care. ... All changes in the assignment will be communicated to the Home Health Aide and will be documented on a new Care Plan."</p> <p>Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on personnel file review, the agency failed to ensure all aides were entered on and in good standing on the state aide registry for 3 of 16 home health aide files reviewed (N, O, and W).</p>	N0597	Human Resource Supervisor terminated from agency 12/09/2011. Orientated another staff member to Human Resource Supervisory position. 100% of all personnel files were audited for	12/30/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0606	<p>Findings include:</p> <p>Personnel files N, O, and W failed to evidence verification the aide was entered on and in good standing on the state aide registry.</p> <p>Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and policy review and interview the agency failed to ensure the registered nurse supervised the aide every two weeks in 5 of 5 clinical records reviewed of patients who received home health aide and skilled nurse services and the agency policy was congruent with federal requirements with the potential to affect all the patients of the agency receiving home health aide services (4, 7, 8, 9 and 10) and failed to ensure the aide was observed giving care every 30 days as required by agency policy in 3 of 4 clinical records reviewed of patients with home health aide only services with the potential to affect all the</p>	N0606	<p>current license/certification verification. Indiana State Home Health Aide Registry was checked to ensure employees in good standing. If CNA checked CNA Registry to ensure CNA license in good standing. Licensure/Certification will be verified and in good standing before hired by agency and DON/Administrator to ensure this rule is met before new staff member has first patient contact.</p> <p>To ensure compliance, purchased new Home Health Aide care plans and Home Health Aide notes that coorelate with care plan. Inserviced 100% of Nurses and Home Health Aides on new documents and proper documentation on forms to match Plan of Care. Inserviced 100% of nurses on 12/22/2011 on policy/Regulation of Home Health Aide supervisory and Home Health needing to be observed providing personal care every 30 days. Aide Supervision form revised to ensure aide present with aide/patient signing form and with observation of personal care being performed every 30 days. 100% of nursing notes will be audited to 485 weekly for 6</p>	12/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>patients of the agency receiving home health aide services (1, 2 and 3).</p> <p>Findings:</p> <p>Related to home health aide and skilled services:</p> <p>1. Clinical record 4, start of care (SOC) 10/27/11, evidenced a plan of care with orders for skilled nursing and home health aide services for the certification period 10/27/11 to 12/25/11. The clinical record failed to evidence a supervisory visits was made for the home health aide until the 7th week.</p> <p>2. Clinical record 7, SOC 8/4/11, evidenced a plan of care with orders for skilled nursing and home health aide services for the certification period 10/3/11 to 12/1/11. The clinical record evidenced a gap between supervisory visits of 21 days between 11/1/11 to 11/22/11.</p> <p>3. Clinical Record # 8, start of care 8/4/11, evidenced a plan of care for the certification period 10/3/11 through 12/1/11 with orders for the skilled nurse (SN) to visit once a day, seven days a week for 9 weeks. ... Home health aide 1 - 3 times a week ... and Home health aide 4 - 8 hours for 1-3 times a day, 4 - 7</p>		<p>months for compliance by Clinical Coordinator/DON/Alternate DON. 100% of Home Health Aide notes will be audited by Staffing Coordinator weekly for compliance of frequencies of specific assigned duties to match home health aide care plan. Any inconsistency will be reported to the Clinical Coordinator/DON/Alternate DON.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>times a week, for 9 weeks for assistance with bathing, dressing, skin and hair care, other ADL'S [activities of daily living]." The clinical record evidenced the registered nurse supervised the aide on 11/14/11 and 11/29/11, a period of 15 days.</p> <p>4. Clinical record 9, SOC 3/17/11, evidences a plan of care for the certification period 9/13/11 to 11/11/11 with orders for skilled nursing, home health aide, and homemaker services. A supervisory visit was not made until the eighth week of the certification period on 10/31/11.</p> <p>5. Clinical record 10, SOC 4/25/10, evidenced a plan of care for the certification period 10/17/11 to 12/15/11 with orders for skilled nursing, home health aide, homemaking, and attendant care services. A supervisory visit was made 10/5/11 for the previous certification period and another supervisory visit was not made until 26 days later on 10/31/11.</p> <p>6. On December 9, 2011, at 11:00 AM, Employee F indicated the supervisory visits had not been made as required.</p> <p>7. A policy approved, 1/28/11, "Home Health Aide Supervision" C-340 states,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"3. Supervisory visits of Home Health Aides shall be according to the following frequency: a. When skilled services are being provided to a client, a Registered Nurse/therapist must make a supervisory visit to the client's residence at last every 30 days (either when the Home Health Aide is absent) to assess relationships and determine whether goals are being met."</p> <p>Related to supervisory visits while the aide was providing care:</p> <p>1. Clinical record 1, start of care (SOC) 8/22/11, evidenced a plan of care for home health aide (HHA) 1 - 4 hours a day, 3 - 6 times a week for 9 weeks for the certification period 10/21/11 to 12/19/11. The clinical record failed to evidence a supervisory visit while the aide was providing care.</p> <p>2. Clinical record 2, SOC 6/2/11, evidenced a plan of care for HHA 2-3 hours a day, 4-5 days a week, x 9 weeks for the certification period 9/30/11 to 11/28/11. The clinical record failed to evidence a supervisory visit while the aide was providing care.</p> <p>3. Clinical record 3, SOC 5/24/11, evidenced a plan of care for HHA 1-2 hours a day, 2-3 times a week x 9 weeks for the certification period 9/21/11 to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2011
NAME OF PROVIDER OR SUPPLIER  CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 523 W PLUM ST CHESTERFIELD, IN46017		
(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	
	<p>11/19/11. The clinical record failed to evidence a supervisory visit while the aide was providing.</p> <p>4. December 9, 2011, at 11:30 AM, Employee indicated the aides were not performing care during the supervisory visits.</p> <p>5. A policy approved 1/28/11 titled "Home Health Aide Supervision", C-340, states, "3. Supervisory visits of Home Health Aides shall be according to the following frequency: b. Home Health Aide services only: When Home Health Aide services are being furnished to a client, who does not require the skilled service of a nurse or therapist, a Registered Nurse must make a supervisory visit to the client's residence at least once every 30 days. Each supervisory visit must occur when the Home Health Aide is providing client care."</p>				