

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K100	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2015
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NAME OF PROVIDER OR SUPPLIER RELIABLE HOME HEALTHCARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2141 N FRANKLIN RD INDIANAPOLIS, IN 46219
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G 0000 Bldg. 00	<p>This visit was for a home health agency federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: 12-3, 12-4, 12-7, and 12-8-2015 Partial Extended Dates: 12-7 and 12-8-15</p> <p>Facility Number: IN 012999</p> <p>Medicaid Number: 201124380</p> <p>Census Service Type: Skilled: 11 Home Health Aide Only: 46 Personal Care Only: 0 Total: 57</p> <p>Survey Sample: Record Review with Home Visit: 5 Record Review without Home Visits: 5</p> <p>Reliable Home Healthcare Services continues to be be precluded from providing a home health aide training and competency evaluation program for the remainder of a period of 2 years, which began 1-13-2015, for being found out of</p>	G 0000		

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

TITLE

(X6) DATE

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

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G 0159 Bldg. 00	<p>compliance with the Conditions of Participation 42 CFR 484.14 Organization, Services, and Administration; 484.16 Group of Professional Personnel; 484.36 Home Health Aide Services; 484.52 Program Evaluation; 484.48 Clinical Records; and 484.55 Comprehensive Assessment of Patients.</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on record review and interview, the agency failed to ensure the physician's plan of care orders addressed the specific duties for home health aide services were individualized to the patients' needs for 7 of 8 patients' clinical records reviewed with home health aide services (Patients</p>	G 0159	1. The Nursing Director has in-serviced all RN casemanagers on creating a patient-specific and physician driven Plan of Care (POC).This education has included the requirement to include specific orders for thehome health aide. These would include but not be limited to specific duties and tasks along	12/30/2015

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	<p>#1, 2, 3, 4, 5, 8, and 9).</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Policy, "Physician Orders/Plan of Care", last reviewed/revised 3-31-15, was reviewed, and stated, "Purpose: To ensure that each patient's care is under the direction of the physician. The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item, drugs, and equipment to be provided by the Agency ... All orders on the CMS 485 (plan of care) will be specific to the client condition and needs." 2. Policy, "Care Planning", last reviewed/revised 3-31-15, was reviewed, and stated, "Information gathered from the initial assessment will identify patient/client care decisions, which will provide the basis for formulation of an individualized Plan of Care." 3. A website "As Our Parents Age", asourparentsage.net/2009/12/17/adls-and-iads-what's-the-difference, defined activities of daily living (ADLs) as "the activities to get going in the morning, to get from place to place using one's body, and to close out the day, such as: walking, bathing, toileting, brushing teeth 		<p>with the frequencies of said tasks. Samples have been demonstrated for all nursing staff to understand the expectations. All RN Case Managers have demonstrated understanding. 12/9/15</p> <ol style="list-style-type: none"> 2. At re-assessment of each patient for recertification, the POC will be amended to include the patient-specific homehealth aide orders including specific duties, tasks and frequencies. This was initiated 12/8/15 and will be ongoing for the 60 days it will take for all patients to be reassessed. This will be completed by each individual RN Case Manager. The Nursing Director/Designee will initially audit 100% of these physician POCs for compliance and verify understanding of this requirement. 2/6/15 3. For all patients who will not be due for a reassessment by 12/30/15, Home Health Aide care plans will be faxed to the MD by the RN Case Managers. This will be verified by the Nursing Director/Designee for compliance. 12/30/15 4. After all patients have been recertified, this requirement will be added to our data points audited for the regularly scheduled 10% of all clinical records audited quarterly as part of the agency's ongoing audit policy. (Ongoing) 5. The Nursing Director/Designee will include in orientation of new nurses the proper way to write Home Health Aide Orders according to this requirement. 	

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	<p>or dentures/oral hygiene, eating, grooming, transferring from bed to chair and vice versa, climbing stairs"; and instrumental activities of daily living (IADLs) as activities done once up, dressed, put together, which support an independent lifestyle "cooking/meal preparation, driving/using public transportation, using telephone, looking up phone numbers, using computer, shopping, keeping track of finances, managing medications, using a prosthetic device, housework, laundry, making and keeping appointments."</p> <p>4. The clinical record of patient #1 was reviewed on 12-7-15. The clinical record contained a plan of care established by a physician for a start of care date of 6-10-13 with a certification period of 11-27-15 to 1-25-16, with orders for "home health aide (HHA) services 4 hours each day, 7 days a week, 2 hours in the AM, 2 hours in the PM, to assist with ADLs (activities of daily living) and IADLs (instrumental activities of daily living) and maintain patient safety." a. Review of registered nurse (RN) prepared HHA plan of care, dated 11-26-15, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "shower at least once per week, wash up when no shower, assist bath-chair, shampoo hair with showers</p>		(Ongoing) 6. The Nursing Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. (Ongoing)	

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	<p>prn (as needed), assist with dressing every visit, clean/file nails at least 1 time each week and prn, soak feet prn patient request, perineal care-stand by assist with bathroom and as needed incontinence, moisture skin after showers and prn patient request for dry skin, walker/wheelchair/cane on standby assist prn, prepare and set up meals when not eating in dining hall, change linens as least one time each week and prn soiled, straighten rooms every visit, laundry at least 1 time each week, and prn soiling, record fluid intake daily (2 liter/day fluid restriction and 4 gm sodium diet ordered), report to RN any change in patient condition or skin condition, falls, ER visits, hospitalizations, changes needed to care plan, changes to schedule, concerns or questions."</p> <p>b. Review of HHA daily visit notes dated 11-27 to 12-7-15 evidenced the HHA documentation in accordance with the HHA plan of care.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Patient will maintain adequate personal hygiene/nutrition with assist of HHA. Pt. will have no falls/injuries/infections/ER visits, skin will remain intact this certification period. Vital [signs} will remain within listed parameters."</p> <p>d. The physician's plan of care order failed to evidence the specific ADL and</p>			

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	<p>IADL duties ordered for the HHA and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #1's specific needs.</p> <p>5. The clinical record of patient #2, was reviewed on 11-7-15. The clinical record start of care date of 9-8-15, and contained a plan of care established by a physician for certification period 11-7-15 to 1-5-16, with orders for home health aide services "6 hours per day, 5 days a week, for 9 weeks to assist with ADLs and IADLs and provide for patient safety in the home."</p> <p>a. Review of registered nurse prepared HHA plan of care, dated 11-6-15, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "shower at least 3 times each week, shampoo hair at least 1 time each week, comb hair at least 2 times each week, mouth care by patient each visit, assist with dressing every visit, clean/file nails at least 1 time each week, perineal care-prn soiling, moisture skin each visit, activity- ambulation/mobility & assist with cane prn & chair bed prn patient activity level, prepare and set up meals every visit, change linens as least one time each week and prn soiling, make bed every visit, straighten rooms</p>			

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	<p>every visit, laundry at least 2 times each week, and prn soiled clothes, linens, report to RN any change in patient condition or skin condition, falls with or without injury, changes needed to care plan, changes to schedule concerns or questions."</p> <p>b. Review of HHA daily visit notes dated 11-7 to 12-3-15 evidenced the HHA documentation in accordance with the HHA plan of care.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Vital signs will remain within listed parameters. Patient will maintain adequate personal hygiene with assist from HHA. Nutritional needs will be met with assistance of HHA. Pt. will remain safely in home with assist of HHA."</p> <p>d. The physician's plan of care order failed to evidence the specific ADL and IADL duties ordered for the HHA and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #2's specific needs.</p> <p>6. The clinical record of patient #3 was reviewed on 12-7-15. The clinical record contained a plan of care established by a physician for a start of care date of 1-31-14 with a certification period of</p>			

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	<p>11-22-15 to 1-20-16, with orders for "home health aide (HHA) services under prior authorization 5 hours each day, 4 days per week, for 9 weeks and under waiver, respite HHA services HHA 5 hours a day up to 60 hours per month for patient care giver respite."</p> <p>a. Review of registered nurse prepared HHA plan of care, dated 11-21-15, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "tub bath if not already done or complete bed bath, assist with dressing if not already done, perineal care every visit and prn soiling, moisture skin after complete bed bath or tub bath, toilet every 2 hours every visit, prepare meals every visit, prepare meals every visit, change linens prn soiling, make bed every visit, straighten rooms every visit, laundry prn patient care giver request, report to RN any change in patient condition or skin condition, falls with or without injury, changes needed to care plan, changes to schedule concerns or questions."</p> <p>b. Review of HHA visit notes dated 11-21 to 12-7-15, evidenced the HHA documentation was in accordance with the HHA plan of care, and the HHA furnished, per care giver request, 5 hours of respite care on 11-24 and 11-25-15.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Vital</p>			

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	<p>signs will remain within listed parameters. Patient will remain safe in the home and maintain adequate hydration/nutrition with assist of HHA. Patient will remain free from seizures lasting longer than 5 minutes, Skin will remain intact. Vital[signs] will remain within listed parameters."</p> <p>d. The physician's plan of care order failed to evidence specific ADL and IADL duties of the HHA and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #3's specific needs.</p> <p>7. The clinical record of patient #4 was reviewed on 12-7-15. The clinical record contained a plan of care established by a physician for a start of care date of 1-31-14 with a certification period of 11-22-15 to 1-20-16, with orders for "home health aide (HHA) services under prior authorization 5 hours each day, 4 days per week, for 9 weeks and under waiver, respite HHA services HHA 5 hours a day up to 60 hours per month for patient care giver respite."</p> <p>a. Review of registered nurse prepared HHA plan of care, dated 11-21-5, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "tub bath if not already done or complete bed bath, assist with</p>			

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	<p>dressings if not already done, perineal care every visit and prn soiling, moisture skin after complete bed bath or tub bath, toilet every 2 hours every visit, prepare meals every visit, prepare meals every visit, change linens prn soiling, make bed every visit, straighten rooms every visit, laundry prn patient care giver request, report to RN any change in patient condition or skin condition, falls with or without injury, changes needed to care plan, changes to schedule concerns or questions."</p> <p>B. Review of HHA visit notes dated 11-21 to 12-7015, evidenced the HHA evidenced the HHA documentation was in accordance with the HHA plan of care and furnished, per care giver request, 5 hours of respite care on 11-24 and 11-25-15.</p> <p>ac. Goals listed for HHA services on the physician's plan of care were: "Vital signs will remain within listed parameters. Patient will remain safe in the home and maintain adequate hydration/nutrition with assist of HHA. Patient will remain free from seizures lasting longer than 5 minutes, Skin will remain intact. Vital[signs] will remain within listed parameters."</p> <p>d. The physician's plan of care order failed to evidence specific ADL and IADL duties of the HHA and the frequencies with which the duties were to</p>			

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	<p>be performed. The plan of care order for HHA services was not individualized to patient #4's specific needs.</p> <p>8. The clinical record of patient #5 was reviewed on 12-7-15. The clinical record contained a plan of care established by a physician for a start of care date of 7-29-15 with a certification period of 11-26-15 to 1-24-16, with orders for "home health aide (HHA) services 2 hours each day, 3 days a week, for 9 weeks to assist with ADLs and IADLs and maintain patient safety in the home."</p> <p>a. Review of the RN prepared HHA plan of care, dated 11-25-5, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "shower or partial bath every visit, shampoo hair 1 time each week or every other week, assist with dressing every visit, perineal care prn incontinence, moisture skin per patient request, assist with mobility stand by assist, prepare meals per patient request, set up meals per patient request, make bed per patient request, straighten rooms per patient request, laundry prn patient request and prn soiled clothes, report to RN any falls or injuries, changes in skin or open wound, changes needed to care plan or schedule, any questions or concerns, ER visits, missed dialysis appointments."</p> <p>B. Review of HHA visit notes dated</p>			

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	<p>11-26 to 12-7-15, evidenced the HHA documentation was in accordance with the HHA plan of care.</p> <p>ac. Goals listed for HHA services on the physician's plan of care were: "Patient will remain safe in home, maintain skin integrity, have no falls, and maintain hydration/nutrition with assist of HHA this certification period. Vital [signs] will remain within listed parameters. Patient will remain safe in the home and maintain adequate hydration/nutrition with assist of HHA. Patient will have no central line complications."</p> <p>d. The physician's plan of care order failed to evidence specific duties of the HHA and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #5's specific needs.</p> <p>9. The clinical record of patient #8 was reviewed on 12-8-15. The clinical record contained a plan of care established by a physician for a start of care date of 12-10-13, with a certification period of 4-6 to 6-4-15, with orders for "home health aide (HHA) services for respite care up to 60 hours each month as requested by the care giver through Medicaid waiver, usually provided 5 hours on Tuesday, Thursday, and Saturday evening."</p>			

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	<p>a. Review of RN prepared HHA plan of care, dated 4-2-15, evidenced "assist bat chair every visit, shampoo hair every Tuesday or Wednesday, comb hair every visit, mouth care every visit, assist with dressing every visit, perineal care-check diaper every 2 hours and perineal care prn soiling, moisture skin every visit, activity- ambulation/mobility & assist with wheelchair, stander to chair to bed and vice versa, reposition patient every visit, prepare, feed, and set up meals per care giver request, make bed every visit, straighten rooms every visit, change linens prn care giver request, laundry prn care giver request, up in E2 stander 1 hour each visit, 2 times a visit if visit greater than 4 hours, check skin every visit, report to RN any change in patient condition or skin condition, falls, changes in skin integrity, changes in mental status, concerns or questions, changes needed to care plan.</p> <p>b. Review of HHA visit notes dated 4 -6 to 5-14-15, evidenced the HHA documentation was in accordance with the HHA plan of care.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Patient will maintain adequate personal hygiene and remain safe in the home with the assist of HHA. Skin will remain intact this certification period."</p> <p>d. The physician's plan of care order</p>			

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	<p>failed to evidence specific duties of the HHA for respite care and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #8's specific needs.</p> <p>10. The clinical record of patient #9 was reviewed on 12-8-15. The clinical record contained a plan of care established by a physician for a start of care date of 10-3-14, with a certification period of 5-30 to 7-28-15, with orders for "home health aide (HHA) services 4 hours each day, 4 days a week, for assistance with ADLs and IADLs and maintain patient safety per Indiana Medicaid Prior Authorization."</p> <p>a. Review of the RN prepared HHA plan of care, dated 5-29-15, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "tub/shower every Monday and Saturday, shampoo hair self care, comb hair self care, mouth care self care, shave self care, clean nails, do not cut, 2 times each week, perineal care every visit with incontinence, stand by assist with all ambulation (wheelchair, cane), prepare meals every visit, set up meals every visit, change bed linens once weekly and prn soiling, make bed every visit, straighten rooms every visit, laundry on Monday and Saturday, non-weight</p>			

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	<p>bearing as much as possible to right foot, patient to wear walking boot on right foot when weight bearing, report to RN any change in patient condition, falls, ER visits, changes needed to care plan or schedule, questions or concerns."</p> <p>b. Review of HHA visit notes dated 5 -30 to 7-28-15, evidenced the HHA documentation was in accordance with the HHA plan of care.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Patient will maintain adequate personal hygiene, maintain skin integrity, have nutritional needs met, and remain safe in home with assist of HHA. Vital [signs] will remain within listed parameters. Patient will verbalize when MD to be contacted for pain. Patient will allow peri-care, compression wraps, and wear off-loading boot daily this certification period."</p> <p>d. The physician's plan of care order failed to evidence specific duties of the HHA and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #9's specific needs.</p> <p>11. On 12-8-15 at 3:30 PM, the nursing supervisor indicated the physician had not approved a plan of care order for home health aide services which specified the duties within ADLS and</p>			

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N 0000 Bldg. 00	<p>IADLs, or the frequency with which the duties were to be performed. The nursing supervisor verified the above findings.</p> <p>This visit was for an extended home health agency state re-licensure survey.</p> <p>Survey Dates: 12-3, 12-4, 12-7, and 12-8-2015 Extended Dates: 12-7 and 12-8-15</p> <p>Facility Number: IN 012999</p> <p>Medicaid Number: 201124380</p> <p>Census Service Type: Skilled: 11 Home Health Aide Only: 46 Personal Care Only: 0 Total: 57</p> <p>Survey Sample: Record Review with Home Visit: 5 Record Review without Home Visits: 5</p>	N 0000		

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N 0524 Bldg. 00	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on record review and interview, the agency failed to ensure the physician's plan of care orders addressed the specific duties for home health aide services were individualized to the patients' needs for 7 of 8 patients' clinical records reviewed with home health aide services (Patients #1, 2, 3, 4, 5, 8, and 9) and failed to ensure all orders for services included the duration of services for 1 of 10 clinical records reviewed (Patient #9).</p>	N 0524	<p>1. The Nursing Director has in-serviced all RN casemanagers on creating a patient-specific and physician driven Plan of Care (POC). This education has included the requirement to include specific orders for the home health aide. These would include but not be limited to specific duties and tasks along with the frequencies of said tasks. Samples have been demonstrated for all nursing staff to understand the expectations.</p>	12/30/2015			

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	<p>The findings included:</p> <ol style="list-style-type: none"> 1. Policy, "Physician Orders/Plan of Care", last reviewed/revised 3-31-15, was reviewed, and stated, "Purpose: To ensure that each patient's care is under the direction of the physician. The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, an order for each service, item, drugs, and equipment to be provided by the Agency ... All orders on the CMS 485 (plan of care) will be specific to the client condition and needs." 2. Policy, "Care Planning", last reviewed/revised 3-31-15, was reviewed, and stated, "Information gathered from the initial assessment will identify patient/client care decisions, which will provide the basis for formulation of an individualized Plan of Care." 3. A website "As Our Parents Age", asourparentsage.net/2009/12/17/adls-and-iads-what's-the-difference, defined activities of daily living (ADLs) as "the activities to get going in the morning, to get from place to place using one's body, and to close out the day, such as: walking, bathing, toileting, brushing teeth or dentures/oral hygiene, eating, 		<p>All RN Case Managers have demonstrated understanding. 12/9/15 2. At re-assessment of each patient for recertification, the POC will be amended to include the patient-specific homehealth aide orders including specific duties, tasks and frequencies. This was initiated 12/8/15 and will be ongoing for the 60 days it will take for all patients to be reassessed. This will be completed by each individual RN Case Manager. The Nursing Director/Designee will initially audit 100% of these physician POCs for compliance and verify understanding of this requirement. 2/6/15 3. For all patients who will not be due for a reassessment by 12/30/15, Home Health Aide care plans will be faxed to the MD by the RN Case Managers. This will be verified by the Nursing Director/Designee for compliance. 12/30/15 4. After all patients have been recertified, this requirement will be added to our data points audited for the regularly scheduled 10% of all clinical records audited quarterly as part of the agency's ongoing audit policy. (Ongoing) 5. The Nursing Director/Designee will include in orientation of new nurses the proper way to write Home Health Aide Orders according to this requirement. (Ongoing) 6. The Nursing Director will be responsible for monitoring these corrective actions to ensure that this</p>		

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	<p>grooming, transferring from bed to chair and vice versa, climbing stairs"; and instrumental activities of daily living (IADLs) as activities done once up, dressed, put together, which support an independent lifestyle "cooking/meal preparation, driving/using public transportation, using telephone, looking up phone numbers, using computer, shopping, keeping track of finances, managing medications, using a prosthetic device, housework, laundry, making and keeping appointments."</p> <p>4. The clinical record of patient #1 was reviewed on 12-7-15. The clinical record contained a plan of care established by a physician for a start of care date of 6-10-13 with a certification period of 11-27-15 to 1-25-16, with orders for "home health aide (HHA) services 4 hours each day, 7 days a week, 2 hours in the AM, 2 hours in the PM, to assist with ADLs (activities of daily living) and IADLs (instrumental activities of daily living) and maintain patient safety." a. Review of registered nurse (RN) prepared HHA plan of care, dated 11-26-15, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "shower at least once per week, wash up when no shower, assist bath-chair, shampoo hair with showers prn (as needed), assist with dressing</p>		deficiency is corrected and will not recur. (Ongoing)	

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	<p>every visit, clean/file nails at least 1 time each week and prn, soak feet prn patient request, perineal care-stand by assist with bathroom and as needed incontinence, moisture skin after showers and prn patient request for dry skin, walker/wheelchair/cane on standby assist prn, prepare and set up meals when not eating in dining hall, change linens as least one time each week and prn soiled, straighten rooms every visit, laundry at least 1 time each week, and prn soiling, record fluid intake daily (2 liter/day fluid restriction and 4 gm sodium diet ordered), report to RN any change in patient condition or skin condition, falls, ER visits, hospitalizations, changes needed to care plan, changes to schedule, concerns or questions."</p> <p>b. Review of HHA daily visit notes dated 11-27 to 12-7-15 evidenced the HHA documentation in accordance with the HHA plan of care.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Patient will maintain adequate personal hygiene/nutrition with assist of HHA. Pt. will have no falls/injuries/infections/ER visits, skin will remain intact this certification period. Vital [signs} will remain within listed parameters."</p> <p>d. The physician's plan of care order failed to evidence the specific ADL and IADL duties ordered for the HHA and</p>			

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	<p>the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #1's specific needs.</p> <p>5. The clinical record of patient #2, was reviewed on 12-7-15. The clinical record contained a plan of care established by a physician with start of care date of 9-8-15, and contained a plan of care for certification period 11-7-15 to 1-5-16, with orders for home health aide services "6 hours per day, 5 days a week, for 9 weeks to assist with ADLs and IADLs and provide for patient safety in the home."</p> <p>a. Review of registered nurse prepared HHA plan of care, dated 11-6-15, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "shower at least 3 times each week, shampoo hair at least 1 time each week, comb hair at least 2 times each week, mouth care by patient each visit, assist with dressing every visit, clean/file nails at least 1 time each week, perineal care-prn soiling, moisture skin each visit, activity- ambulation/mobility & assist with cane prn & chair bed prn patient activity level, prepare and set up meals every visit, change linens as least one time each week and prn soiling, make bed every visit, straighten rooms</p>			

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	<p>every visit, laundry at least 2 times each week, and prn soiled clothes, linens, report to RN any change in patient condition or skin condition, falls with or without injury, changes needed to care plan, changes to schedule concerns or questions."</p> <p>b. Review of HHA daily visit notes dated 11-7 to 12-3-15 evidenced the HHA documentation in accordance with the HHA plan of care.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Vital signs will remain within listed parameters. Patient will maintain adequate personal hygiene with assist from HHA. Nutritional needs will be met with assistance of HHA. Pt. will remain safely in home with assist of HHA."</p> <p>d. The physician's plan of care order failed to evidence the specific ADL and IADL duties ordered for the HHA and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #2's specific needs.</p> <p>6. The clinical record of patient #3 was reviewed on 12-7-15. The clinical record contained a plan of care established by a physician for a start of care date of 1-31-14 with a certification period of</p>			

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	<p>11-22-15 to 1-20-16, with orders for "home health aide (HHA) services under prior authorization 5 hours each day, 4 days per week, for 9 weeks and under waiver, respite HHA services HHA 5 hours a day up to 60 hours per month for patient care giver respite."</p> <p>a. Review of registered nurse prepared HHA plan of care, dated 11-21-15, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "tub bath if not already done or complete bed bath, assist with dressing if not already done, perineal care every visit and prn soiling, moisture skin after complete bed bath or tub bath, toilet every 2 hours every visit, prepare meals every visit, prepare meals every visit, change linens prn soiling, make bed every visit, straighten rooms every visit, laundry prn patient care giver request, report to RN any change in patient condition or skin condition, falls with or without injury, changes needed to care plan, changes to schedule concerns or questions."</p> <p>b. Review of HHA visit notes dated 11-21 to 12-7-15, evidenced the HHA documentation was in accordance with the HHA plan of care, and the HHA furnished, per care giver request, 5 hours of respite care on 11-24 and 11-25-15.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Vital</p>			

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	<p>signs will remain within listed parameters. Patient will remain safe in the home and maintain adequate hydration/nutrition with assist of HHA. Patient will remain free from seizures lasting longer than 5 minutes, Skin will remain intact. Vital[signs] will remain within listed parameters."</p> <p>d. The physician's plan of care order failed to evidence specific ADL and IADL duties of the HHA and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #3's specific needs.</p> <p>7. The clinical record of patient #4 was reviewed on 12-7-15. The clinical record contained a plan of care established by a physician for a start of care date of 1-31-14 with a certification period of 11-22-15 to 1-20-16, with orders for "home health aide (HHA) services under prior authorization 5 hours each day, 4 days per week, for 9 weeks and under waiver, respite HHA services HHA 5 hours a day up to 60 hours per month for patient care giver respite."</p> <p>a. Review of registered nurse prepared HHA plan of care, dated 11-21-5, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "tub bath if not already done or complete bed bath, assist with</p>			

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	<p>dressings if not already done, perineal care every visit and prn soiling, moisture skin after complete bed bath or tub bath, toilet every 2 hours every visit, prepare meals every visit, prepare meals every visit, change linens prn soiling, make bed every visit, straighten rooms every visit, laundry prn patient care giver request, report to RN any change in patient condition or skin condition, falls with or without injury, changes needed to care plan, changes to schedule concerns or questions."</p> <p>b. Review of HHA visit notes dated 11-21 to 12-7-2015, evidenced the HHA evidenced the HHA documentation was in accordance with the HHA plan of care and furnished, per care giver request, 5 hours of respite care on 11-24 and 11-25-15.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Vital signs will remain within listed parameters. Patient will remain safe in the home and maintain adequate hydration/nutrition with assist of HHA. Patient will remain free from seizures lasting longer than 5 minutes, Skin will remain intact. Vital[signs] will remain within listed parameters."</p> <p>d. The physician's plan of care order failed to evidence specific ADL and IADL duties of the HHA and the frequencies with which the duties were to</p>			

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	<p>be performed. The plan of care order for HHA services was not individualized to patient #4's specific needs.</p> <p>8. The clinical record of patient #5 was reviewed on 12-7-15. The clinical record contained a plan of care established by a physician for a start of care date of 7-29-15 with a certification period of 11-26-15 to 1-24-16, with orders for "home health aide (HHA) services 2 hours each day, 3 days a week, for 9 weeks to assist with ADLs and IADLs and maintain patient safety in the home."</p> <p>a. Review of the RN prepared HHA plan of care, dated 11-25-5, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "shower or partial bath every visit, shampoo hair 1 time each week or every other week, assist with dressing every visit, perineal care prn incontinence, moisture skin per patient request, assist with mobility stand by assist, prepare meals per patient request, set up meals per patient request, make bed per patient request, straighten rooms per patient request, laundry prn patient request and prn soiled clothes, report to RN any falls or injuries, changes in skin or open wound, changes needed to care plan or schedule, any questions or concerns, ER visits, missed dialysis appointments."</p> <p>b. Review of HHA visit notes dated</p>			

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	<p>11-26 to 12-7-15, evidenced the HHA documentation was in accordance with the HHA plan of care.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Patient will remain safe in home, maintain skin integrity, have no falls, and maintain hydration/nutrition with assist of HHA this certification period. Vital [signs] will remain within listed parameters. Patient will remain safe in the home and maintain adequate hydration/nutrition with assist of HHA. Patient will have no central line complications."</p> <p>d. The physician's plan of care order failed to evidence specific duties of the HHA and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #5's specific needs.</p> <p>9. The clinical record of patient #8 was reviewed on 12-8-15. The clinical record contained a plan of care established by a physician for a start of care date of 12-10-13, with a certification period of 4-6 to 6-4-15, with orders for "home health aide (HHA) services for respite care up to 60 hours each month as requested by the care giver through Medicaid waiver, usually provided 5 hours on Tuesday, Thursday, and Saturday evening."</p>			

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NAME OF PROVIDER OR SUPPLIER RELIABLE HOME HEALTHCARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2141 N FRANKLIN RD INDIANAPOLIS, IN 46219
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(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. Review of RN prepared HHA plan of care, dated 4-2-15, evidenced "assist bat chair every visit, shampoo hair every Tuesday or Wednesday, comb hair every visit, mouth care every visit, assist with dressing every visit, perineal care-check diaper every 2 hours and perineal care prn soiling, moisture skin every visit, activity- ambulation/mobility & assist with wheelchair, stander to chair to bed and vice versa, reposition patient every visit, prepare, feed, and set up meals per care giver request, make bed every visit, straighten rooms every visit, change linens prn care giver request, laundry prn care giver request, up in E2 stander 1 hour each visit, 2 times a visit if visit greater than 4 hours, check skin every visit, report to RN any change in patient condition or skin condition, falls, changes in skin integrity, changes in mental status, concerns or questions, changes needed to care plan.</p> <p>b. Review of HHA visit notes dated 4-6 to 5-14-15, evidenced the HHA documentation was in accordance with the HHA plan of care.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Patient will maintain adequate personal hygiene and remain safe in the home with the assist of HHA. Skin will remain intact this certification period."</p> <p>d. The physician's plan of care order</p>			

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	<p>failed to evidence specific duties of the HHA for respite care and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #8's specific needs.</p> <p>10. The clinical record of patient #9 was reviewed on 12-8-15. The clinical record contained a plan of care established by a physician for a start of care date of 10-3-14, with a certification period of 5-30 to 7-28-15, with orders for "home health aide (HHA) services 4 hours each day, 4 days a week, for assistance with ADLs and IADLs and maintain patient safety per Indiana Medicaid Prior Authorization."</p> <p>a. Review of the RN prepared HHA plan of care, dated 5-29-15, evidenced the registered nurse had delegated the following duties to the assigned HHAs: "tub/shower every Monday and Saturday, shampoo hair self care, comb hair self care, mouth care self care, shave self care, clean nails, do not cut, 2 times each week, perineal care every visit with incontinence, stand by assist with all ambulation (wheelchair, cane), prepare meals every visit, set up meals every visit, change bed linens once weekly and prn soiling, make bed every visit, straighten rooms every visit, laundry on Monday and Saturday, non-weight</p>			

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	<p>bearing as much as possible to right foot, patient to wear walking boot on right foot when weight bearing, report to RN any change in patient condition, falls, ER visits, changes needed to care plan or schedule, questions or concerns."</p> <p>b. Review of HHA visit notes dated 5 -30 to 7-28-15, evidenced the HHA documentation was in accordance with the HHA plan of care.</p> <p>c. Goals listed for HHA services on the physician's plan of care were: "Patient will maintain adequate personal hygiene, maintain skin integrity, have nutritional needs met, and remain safe in home with assist of HHA. Vital [signs] will remain within listed parameters. Patient will verbalize when MD to be contacted for pain. Patient will allow peri-care, compression wraps, and wear off-loading boot daily this certification period."</p> <p>d. The physician's plan of care order failed to evidence specific duties of the HHA and the frequencies with which the duties were to be performed. The plan of care order for HHA services was not individualized to patient #9's specific needs. The order for HHA services failed to evidence a duration for the order.</p> <p>11. On 12-8-15 at 3:30 PM, the nursing supervisor indicated the physician had not approved a plan of care order for home health aide services which</p>			

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	specified the duties within ADLS and IADLs, or the frequency with which the duties were to be performed. The nursing supervisor verified the above findings.				