

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/08/2014
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NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 973 EMERSON PARKWAY SUITE B GREENWOOD, IN 46143
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G000000	<p>This was a federal home health recertification survey. The survey was partial extended</p> <p>Survey dates: 8/5/2014 through 8/8/2014</p> <p>Facility # IN004617</p> <p>Medicaid # 200533880</p> <p>Surveyors: Nina Koch, RN, PHNS Deborah Franco, RN, PHNS</p> <p>Census: 216 Skilled unduplicated admissions, twelve months 60 Active patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 12, 2014</p>	G000000		

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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G000159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and agency policy review, home visit observation, and interview, the agency failed to ensure the plans of care included specific interventions with measurable goals for 3 of 12 clinical records reviewed (#s 2, 3, and 12) and included durable medical equipment (DME) required for 1 of 12 (#5) clinical records reviewed with the potential to affect all of the agency's 60 current active patients.</p> <p>Findings:</p> <p>1. Clinical record number 2, primary diagnosis CHF (congestive heart failure) and start of care 2/19/2014, contained a plan of care for the certification period 2/19/2014 through 4/19/2014 The plan of care failed to evidence measurable goals with specific interventions and teaching for CHF.</p>	G000159	<p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with physician orders was done at the 8/14/14 mandatory staff meeting conducted by the Director of Nursing/Director of Professional Services (DPS).</p> <p>Re-education including review of policies & requirements as they relate to: plan of care and provision of care in accordance with physician orders, including: 1. Medical plan of care shall include all services to be provided including the types of services and equipment required. 2. Medical plan shall include specific intervention with measurable goals. All staff were re-educated in the principles of the following policy:</p> <p>.2.17 Plan of Care</p>	08/14/2014

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	<p>2. Clinical record number 3, primary diagnosis diabetes and start of care 10/11/2013, contained a plan of care for the certification period 8/7/2014 through 10/5/2014 that stated "Goals: ... Administration of insulin, patient / caregiver will verbalize purpose, action, response and side effects of insulin by the end of episode." A comprehensive assessment of the patient completed on 8/4/2014 indicated the patient has dementia, is able to follow only one step commands, is unable to take injectable meds unless administered by another person, and has no willing caregiver.</p> <p>3. Clinical record number 5, primary diagnosis of Left Hip Total Joint Replacement and start of care 6-16-2014, contained a plan of care for the certification period 6-16-2014 to 8-14-2014 that stated under item 14, DME and Supplies, "NONE." During a home visit on 8-6-2014 beginning at 10:00 AM, a wheelchair, 2 canes, 2 walkers, a bath chair, and an elevated toilet seat were observed to be in the home and used for ADL and with the Occupational Therapist during the therapy session.</p> <p>4. Clinical record number 12, diagnoses hypertension, CHF, diabetes, and start of</p>		<p>All written plans of care (485s) will be reviewed by Directors of Nursing/designee, as part of the admission review, for inclusion of types of service and equipment required and specific interventions with measurable goals.</p> <p>Ongoing monitoring of documentation will be performed by the DPS/designee monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p>	

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	<p>care 2/14/2014, contained a plan of care for the certification period 4/15/2014 through 6/13/2014 that failed to evidence measurable goals with specific interventions for hypertension, diabetes, and CHF.</p> <p>5. An agency policy dated 4/1998 and revised 1/2007 titled 2.17 Plan of Care states "The plan will identify medical and or psychosocial problems and methods to resolve prevent or decrease those problems. The patient's needs, goals, specific time frames, settings and services needed as identified by assessment data obtained during patient visits will determine the development of a patient specific plan for care, treatment and services."</p> <p>6. The administrator and Director of Nursing agreed during exit conference on 8/8/2014 at 4 PM that the plan of care should be patient specific and contain measurable goals and interventions and the 7 items of DME for #5 were not on the plan of care and should have been.</p>			

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G000164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record and agency policy review, the agency failed to ensure professional staff promptly alerted the physician to abnormal blood sugar levels for 2 (# 7 and 8) of 12 records reviewed with the potential to affect all of the agency's 60 active patients.</p> <p>Findings:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification period 6/5/2014 through 8/3/2014 that identified the patient had a diagnosis of diabetes mellitus type 2 and parameters to report FBS (fasting blood sugars) less than 80 and greater than 180 to the patient's physician.</p> <p>A. The 6/10/2014 skilled nursing visit note evidenced the patient's FBS glucometer readings ranged from 232-525. The record failed to evidence the</p>	G000164	<p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with policy and regulations in regards to professional staff to promptly alert the physician to any changes that suggest a need to alter the plan of care at the 8/14/14 mandatory staff meeting conducted by the Director of Nursing/Director of Professional Services (DPS).</p> <p>Continued re-education of all agency staff on the requirements as they relate to physician notification of any changes that suggest the need to alter the plan of care. Re-education to be completed by DPS by 8/21/14.</p> <p>All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment 	08/14/2014

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	<p>physician was notified about the elevated FBS.</p> <p>B. The 7/17/2014 skilled nursing visit note evidenced the patient's FBS ranged from 90-525. The record failed to evidence the physician was notified about the elevated FBS.</p> <p>C. In a medical record coordination note completed by the RN (registered nurse) case manager, dated 6/10/2014, the nurse documented, "Last physician visit to PCP [primary care physician] 5/30/2014, ... the patient does not monitor blood glucose [BG] routinely, last BG 381 on 6/8/2014." The clinical record failed to evidence the physician was notified of the patient's non-compliance with BG monitoring and elevated FBS.</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 6/16/2014 through 8/14/2014 that identified the patient had a diagnosis of diabetes mellitus type 2 and parameters to report FBS of less than 80 and greater than 180 to the patient's physician.</p> <p>The clinical record evidenced skilled nursing notes from numerous dates (6/17, 6/19, 6/20, 6/23, 6/24, 7/10, 7/11,</p>		<ul style="list-style-type: none"> · 2.17 Plan of Care · 2.18 Verbal Orders <p>Ongoing monitoring of prompt physician notification of clinical changes documentation will be performed by the DPS/designee monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>				

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G000173	<p>7/15, 7/16, 7/30, and 7/31/2014) the patient had FBS readings outside of the parameters ordered. The record failed to evidence the physician was notified.</p> <p>3. An agency policy dated 11/1996 and revised 9/2005 titled "2.3 Physician Responsibility" states, "The homecare organization is equally responsible for providing information on a regular basis to the physician to assist the provision of care and delivery of services to the patient."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review and interview, the registered nurse failed to revise the plan of care for a change in diagnosis for 1 of 12 clinical records reviewed (#1) with the potential to affect all agency patients receiving skilled nursing services.</p> <p>Findings included:</p>	G000173	Re-education with all registered nurse staff regarding professional expectations as they relate to the responsibility to update and revise the plan of care was performed at the 8/14/14 mandatory staff meeting. This re-education was completed by the Director of Nursing/Director of Professional	08/14/2014

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	<p>1. Clinical record number #1, start of care date 12-20-2013, included a plan of care established by the physician for the certification period 4-19-014 through 6-17-2014.</p> <p>At start of care on 12-20-2013, medications included Warfarin 4 mg (milligram) daily. By physician order Warfarin was discontinued on 1-3-2014. Warfarin was removed from the medication profile. The plan of care for the 2nd certification period of 2-18-2014 to 4-18-2014 continued to list "Encounter Long-Term Use Anticoagulant" as a diagnosis. The plan of care for the 3rd certification period of 4-19-2014 to 6-17-2014 continued to list "Encounter Long-Term Use Anticoagulant" as a diagnosis.</p> <p>2. The Administrator and DON agreed during exit conference on 8-8-2014 at 4 PM the plans of care established for the 2nd and 3rd certification periods for patient #1 (after the Warfarin had been discontinued on 1-3-2014) should have been revised to remove the diagnosis of "Encounter Long-Term Use of Anticoagulant" as an other diagnosis.</p>		<p>Services on 8/14/14.</p> <p>Continued re-education of all registered nurse staff on the requirements as they relate to the responsibility to update and revise the plan of care including revising the diagnosis. Re-education to be completed by DPS by 8/22/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC at the start of care, recertification and resumption of care to ensure proper establishment of the POC, including revision of diagnosis.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established</p>	

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G000176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record and agency policy review, the agency failed to ensure the registered nurse promptly alerted the physician to abnormal blood sugar levels for 2 (# 7 and 8) of 12 records reviewed with the potential to affect all of the agency's 60 active patients.</p> <p>Findings:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification period 6/5/2014 through 8/3/2014 that identified the patient had a diagnosis of diabetes mellitus type 2 and parameters to report FBS (fasting blood sugars) less than 80 and greater than 180 to the patient's physician.</p>	G000176	<p>benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with policy and regulations in regards to professional staff to promptly alert the physician to any changes that suggest a need to alter the plan of care at the 8/14/14 mandatory staff meeting conducted by the Director of Nursing/Director of Professional Services (DPS).</p> <p>Continued re-education of all agency staff on the requirements as they relate to physician notification of any changes that suggest the need to alter the plan of care. Re-education to be completed by DPS by 8/21/14.</p>	08/14/2014

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	<p>A. The 6/10/2014 skilled nursing visit note evidenced the patient's FBS glucometer readings ranged from 232-525. The record failed to evidence the physician was notified about the elevated FBS.</p> <p>B. The 7/17/2014 skilled nursing visit note evidenced the patient's FBS ranged from 90-525. The record failed to evidence the physician was notified about the elevated FBS.</p> <p>C. In a medical record coordination note completed by the RN (registered nurse) case manager, dated 6/10/2014, the nurse documented, "Last physician visit to PCP [primary care physician] 5/30/2014, ... the patient does not monitor blood glucose [BG] routinely, last BG 381 on 6/8/2014." The clinical record failed to evidence the physician was notified of the patient's non-compliance with BG monitoring and elevated FBS.</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 6/16/2014 through 8/14/2014 that identified the patient had a diagnosis of diabetes mellitus type 2 and parameters to report FBS of less than 80 and greater than 180 to the patient's physician.</p>		<p>All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.18 Verbal Orders <p>Ongoing monitoring of prompt physician notification of clinical changes documentation will be performed by the DPS/designee monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal</p>	

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G000321	<p>The clinical record evidenced skilled nursing notes from numerous dates (6/17, 6/19, 6/20, 6/23, 6/24, 7/10, 7/11, 7/15, 7/16, 7/30, and 7/31/2014) the patient had FBS readings outside of the parameters ordered. The record failed to evidence the physician was notified.</p> <p>3. An agency policy dated 11/1996 and revised 9/2005 titled "2.3 Physician Responsibility" states, "The homecare organization is equally responsible for providing information on a regular basis to the physician to assist the provision of care and delivery of services to the patient."</p> <p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set. Based on Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of the M0090 date in 3 (#s 1, 3 and 12) of 12 records reviewed of patients whose OASIS should have been transmitted within 30 days creating the potential to affect all of the agency's patients who require OASIS to be transmitted.</p>	G000321	<p>Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all agency staff regarding professional expectations as they relate to OASIS data must be transmitted within 30 days of completion was performed during the mandatory staff meeting. This education was completed by the DON/DPS on 8/14/14.</p> <p>Continued re-education of staff on</p>	08/14/2014

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	<p>Findings:</p> <ol style="list-style-type: none"> 1. An ISDH document dated 8/1/2014 evidenced a transfer assessment had been completed on 4/23/2014 for patient number 1. The document evidenced the OASIS data had not been transmitted until 5/29/2014. A recertification assessment was completed on 4/14/2014. The ISDH document evidenced the OASIS data had not been transmitted until 5/29/2014. 2. An ISDH document dated 8/1/2014 evidenced a recertification assessment was completed for patient number 3 on 4/4/2014. The document evidenced the OASIS data had not been submitted until 5/29/2014. 3. An ISDH document dated 8/1/2014 evidenced a start of care assessment had been completed on 2/14/2014 for patient number 12. The document evidenced the OASIS data had not been transmitted until 4/23/2014. A discharge assessment was completed on 6/11/2014. The ISDH document evidenced the OASIS data had not been transmitted until 7/24/2014. 4. The Director of Nursing and the Administrator were unable to provide any additional documentation and/or 		<p>policies & requirements as they relate to: OASIS data must be transmitted within 30 days of completion . Re-Education to be completed by DPS by 8/22/14. All staff will be re-educated in and principles of the following policies:</p> <p>5.2 Information Management</p> <ul style="list-style-type: none"> · All OASIS data will be transmitted within no greater than 30 days following completion of the data set. · <p>The DPS will monitor using the OASIS Validation Reports that are obtained with each submission; Additionally every quarter the DPS will review the submission statistic and error summary report from the Casper reports.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action</p>	

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N000000	<p>information when asked during the daily survey conference on 8-5-14 at 4 PM.</p> <p>This was a home health state reclicensure survey</p> <p>Survey dates: 8/5/2014 through 8/8/2014</p> <p>Facility # IN004617</p> <p>Medicaid # 200533880</p> <p>Surveyors: Nina Koch, RN, PHNS Deborah Franco, RN, PHNS</p> <p>Census: 216 Skilled unduplicated admissions, twelve months 60 Active patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 12, 2014</p>	N000000	<p>plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/08/2014
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NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 973 EMERSON PARKWAY SUITE B GREENWOOD, IN 46143
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N000456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on agency policy review, agency document review, and interview, the administrator failed to ensure the agency had ongoing quality assurance program designed to objectively evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of agency documents failed to evidence the agency had a functioning quality improvement program. On 8/7/14 at 4:15 PM, the Administrator indicated the agency had not completed a quality improvement 	N000456	<p>The DPS/designee to perform the quarterly 10% Performance Improvement chart audits, develop plan of correction and conduct Performance Improvement meeting with evidence of Performance Improvement minutes by 9/5/14.</p> <p>Ongoing monitoring of the quality assurance program to objectively and systematically monitor and evaluate the quality and appropriateness of patient care will be performed by the DPS/designee monthly as part of the quarterly 10% Performance Improvement chart audits. The DPS will be responsible for conducting a performance improvement meetings and action plans. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p>	09/05/2014

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N000472	<p>program.</p> <p>3. An agency policy dated 12/00 and revised 6/06 titled "Performance Improvement (PI)Plan" states, " The performance improvement plan shall be evaluated at least annually and revised as necessary ... The agency director is responsible for (a) allocating appropriate resources necessary for assessing and improving performance. Resources include adequate staffing, time and training. (b) Directing activities such as communication, assignment of responsibilities, and appropriate response to recommendations generated through PI activities."</p> <p>410 IAC 17-12-2(a) Q A and performance improvement 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</p>		<p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>	

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	<p>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 policy and administrative document review and interview, the agency failed to implement and maintain a quality assessment and performance improvement program that reflected the complexity of the agency services, included actions for improvement and used objective measures for 1 of 1 agency with the potential to affect all patients served by the agency.</p> <p>Findings:</p> <p>1) A review of agency documents failed to evidence performance improvement committee meeting minutes, data collection and analysis to improve patient outcomes, and evaluation of the agency's performance with recommendations for improving policies and services.</p> <p>2) An agency policy dated 12/2000 and revised 6/2006, titled " Performance Improvement (PI) Plan" states, "The performance improvement committee conducts a formal meeting at least quarterly. ... A copy of the Quarterly PI report is maintained by the director in each office for a minimum of three</p>	N000472	<p>The DPS/designee to perform the quarterly 10% Performance Improvement chart audits, develop plan of correction and conduct Performance Improvement meeting with evidence of Performance Improvement minutes by 9/5/14.</p> <p>Ongoing monitoring of the quality assurance program to objectively and systematically monitor and evaluate the quality and appropriateness of patient care will be performed by the DPS/designee monthly as part of the quarterly 10% Performance Improvement chart audits. The DPS will be responsible for conducting a performance improvement meetings and action plans. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90%</p>	09/05/2014

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N000524	<p>years."</p> <p>3) On 8/7/14 at 4:15 PM, the Administrator indicated the agency had not completed quality improvement documentation and there were no documented minutes for performance improvement committee meetings.</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral.</p>		<p>compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>	

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	<p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record and agency policy review, home visit observation, and interview, the agency failed to ensure the plans of care included specific interventions with measurable goals for 3 of 12 clinical records reviewed (#s 2, 3, and 12) and included durable medical equipment (DME) required for 1 of 12 (#5) clinical records reviewed with the potential to affect all of the agency's 60 current active patients.</p> <p>Findings:</p> <p>1. Clinical record number 2, primary diagnosis CHF (congestive heart failure) and start of care 2/19/2014, contained a plan of care for the certification period 2/19/2014 through 4/19/2014 The plan of care failed to evidence measurable goals with specific interventions and teaching for CHF.</p> <p>2. Clinical record number 3, primary diagnosis diabetes and start of care 10/11/2013, contained a plan of care for the certification period 8/7/2014 through 10/5/2014 that stated "Goals: ... Administration of insulin, patient / caregiver will verbalize purpose, action,</p>	N000524	<p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with physician orders was done at the 8/14/14 mandatory staff meeting conducted by the Director of Nursing/Director of Professional Services (DPS).</p> <p>Re-education including review of policies & requirements as they relate to: plan of care and provision of care in accordance with physician orders, including: 1. Medical plan of care shall include all services to be provided including the types of services and equipment required. 2. Medical plan shall include specific intervention with measurable goals. All staff were re-educated in the principles of the following policy:</p> <p>·2.17 Plan of Care</p> <p>All written plans of care (485s) will be reviewed by Directors of Nursing/designee, as part of the admission review, for inclusion of types of service and equipment required and specific interventions with measurable goals.</p>	08/14/2014

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	<p>response and side effects of insulin by the end of episode." A comprehensive assessment of the patient completed on 8/4/2014 indicated the patient has dementia, is able to follow only one step commands, is unable to take injectable meds unless administered by another person, and has no willing caregiver.</p> <p>3. Clinical record number 5, primary diagnosis of Left Hip Total Joint Replacement and start of care 6-16-2014, contained a plan of care for the certification period 6-16-2014 to 8-14-2014 that stated under item 14, DME and Supplies, "NONE." During a home visit on 8-6-2014 beginning at 10:00 AM, a wheelchair, 2 canes, 2 walkers, a bath chair, and an elevated toilet seat were observed to be in the home and used for ADL and with the Occupational Therapist during the therapy session.</p> <p>4. Clinical record number 12, diagnoses hypertension, CHF, diabetes, and start of care 2/14/2014, contained a plan of care for the certification period 4/15/2014 through 6/13/2014 that failed to evidence measurable goals with specific interventions for hypertension, diabetes, and CHF.</p> <p>5. An agency policy dated 4/1998 and</p>		<p>Ongoing monitoring of documentation will be performed by the DPS/designee monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p>	

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N000527	<p>revised 1/2007 titled 2.17 Plan of Care states "The plan will identify medical and or psychosocial problems and methods to resolve prevent or decrease those problems. The patient's needs, goals, specific time frames, settings and services needed as identified by assessment data obtained during patient visits will determine the development of a patient specific plan for care, treatment and services."</p> <p>6. The administrator and Director of Nursing agreed during exit conference on 8/8/2014 at 4 PM that the plan of care should be patient specific and contain measurable goals and interventions and the 7 items of DME for #5 were not on the plan of care and should have been.</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record and agency policy review, the agency failed to ensure professional staff promptly alerted the physician to abnormal blood sugar levels for 2 (# 7 and 8) of 12 records reviewed with the potential to affect all of the agency's 60 active patients.</p>	N000527	Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with policy and regulations in regards to professional staff to promptly alert the physician to any changes that suggest a need to alter the plan of	08/14/2014

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	<p>Findings:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification period 6/5/2014 through 8/3/2014 that identified the patient had a diagnosis of diabetes mellitus type 2 and parameters to report FBS (fasting blood sugars) less than 80 and greater than 180 to the patient's physician.</p> <p>A. The 6/10/2014 skilled nursing visit note evidenced the patient's FBS glucometer readings ranged from 232-525. The record failed to evidence the physician was notified about the elevated FBS.</p> <p>B. The 7/17/2014 skilled nursing visit note evidenced the patient's FBS ranged from 90-525. The record failed to evidence the physician was notified about the elevated FBS.</p> <p>C. In a medical record coordination note completed by the RN (registered nurse) case manager, dated 6/10/2014, the nurse documented, "Last physician visit to PCP [primary care physician] 5/30/2014, ... the patient does not monitor blood glucose [BG] routinely, last BG 381 on 6/8/2014." The clinical</p>		<p>care at the 8/14/14 mandatory staff meeting conducted by the Director of Nursing/Director of Professional Services (DPS).</p> <p>Continued re-education of all agency staff on the requirements as they relate to physician notification of any changes that suggest the need to alter the plan of care. Re-education to be completed by DPS by 8/21/14.</p> <p>All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.18 Verbal Orders <p>Ongoing monitoring of prompt physician notification of clinical changes documentation will be performed by the DPS/designee monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p>Additionally every agency receives at</p>	

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N000546	<p>record failed to evidence the physician was notified of the patient's non-compliance with BG monitoring and elevated FBS.</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 6/16/2014 through 8/14/2014 that identified the patient had a diagnosis of diabetes mellitus type 2 and parameters to report FBS of less than 80 and greater than 180 to the patient's physician.</p> <p>The clinical record evidenced skilled nursing notes from numerous dates (6/17, 6/19, 6/20, 6/23, 6/24, 7/10, 7/11, 7/15, 7/16, 7/30, and 7/31/2014) the patient had FBS readings outside of the parameters ordered. The record failed to evidence the physician was notified.</p> <p>3. An agency policy dated 11/1996 and revised 9/2005 titled "2.3 Physician Responsibility" states, "The homecare organization is equally responsible for providing information on a regular basis to the physician to assist the provision of care and delivery of services to the patient."</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for</p>		<p>least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>				

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	<p>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 agency policy review, the agency failed to ensure the registered nurse promptly alerted the physician to abnormal blood sugar levels for 2 (# 7 and 8) of 12 records reviewed with the potential to affect all of the agency's 60 active patients.</p> <p>Findings:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification period 6/5/2014 through 8/3/2014 that identified the patient had a diagnosis of diabetes mellitus type 2 and parameters to report FBS (fasting blood sugars) less than 80 and greater than 180 to the patient's physician.</p> <p>A. The 6/10/2014 skilled nursing visit note evidenced the patient's FBS glucometer readings ranged from 232-525. The record failed to evidence the physician was notified about the elevated FBS.</p>	N000546	<p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with policy and regulations in regards to professional staff to promptly alert the physician to any changes that suggest a need to alter the plan of care at the 8/14/14 mandatory staff meeting conducted by the Director of Nursing/Director of Professional Services (DPS).</p> <p>Continued re-education of all agency staff on the requirements as they relate to physician notification of any changes that suggest the need to alter the plan of care. Re-education to be completed by DPS by 8/21/14.</p> <p>All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment 	08/14/2014	

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	<p>B. The 7/17/2014 skilled nursing visit note evidenced the patient's FBS ranged from 90-525. The record failed to evidence the physician was notified about the elevated FBS.</p> <p>C. In a medical record coordination note completed by the RN (registered nurse) case manager, dated 6/10/2014, the nurse documented, "Last physician visit to PCP [primary care physician] 5/30/2014, ... the patient does not monitor blood glucose [BG] routinely, last BG 381 on 6/8/2014." The clinical record failed to evidence the physician was notified of the patient's non-compliance with BG monitoring and elevated FBS.</p> <p>2. Clinical record number 8 included a plan of care established by the physician for the certification period 6/16/2014 through 8/14/2014 that identified the patient had a diagnosis of diabetes mellitus type 2 and parameters to report FBS of less than 80 and greater than 180 to the patient's physician.</p> <p>The clinical record evidenced skilled nursing notes from numerous dates (6/17, 6/19, 6/20, 6/23, 6/24, 7/10, 7/11, 7/15, 7/16, 7/30, and 7/31/2014) the patient had FBS readings outside of the</p>		<ul style="list-style-type: none"> · 2.17 Plan of Care · 2.18 Verbal Orders <p>Ongoing monitoring of prompt physician notification of clinical changes documentation will be performed by the DPS/designee monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>	

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S000458	<p>parameters ordered. The record failed to evidence the physician was notified.</p> <p>3. An agency policy dated 11/1996 and revised 9/2005 titled "2.3 Physician Responsibility" states, "The homecare organization is equally responsible for providing information on a regular basis to the physician to assist the provision of care and delivery of services to the patient."</p> <p>410 IAC 17-12-1(f) Home health agency administration/management 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: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on personnel file and policy review and interview, the agency failed to ensure annual performance evaluations</p>	S000458	Employees B,H, and I to have complete annual evaluation including supervisory visit by 9/1/14.	09/01/2014

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NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 973 EMERSON PARKWAY SUITE B GREENWOOD, IN 46143
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	<p>were performed for 3 of 5 (#s B, H, and I) employee files reviewed with potential to affect all patients receiving services from these employees.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The personnel files employees #B, H, and I failed to include evidence of annual performance evaluations. <ol style="list-style-type: none"> a. Employee B, an Occupational Therapist, was hired on 11-10-2003. The most recent performance evaluation was dated 1-6-2012. b. Employee H, a registered nurse (RN), was hired 7-8-2011. The most recent performance evaluation was dated 1-9-2012. c. Employee I, a RN, was hired 1-22-2007. The most recent performance evaluation was dated 10-27-2011. 2. Agency policy 6.5 "Performance Appraisals", adopted 2-1991 and most recently revised 5-2003, stated, "PROCEDURE: 1. ... For direct patient care staff, a supervisory visit is conducted annually and is included in the performance appraisal process." 3. During interview with Employee N, 		<p>Re-education given 8/14/14 at the mandatory staff meeting regarding the requirement of an annual performance evaluation in addition to an onsite supervisory visit for direct care workers annually, as stated in the policy:</p> <ul style="list-style-type: none"> · 6.5 Performance Appraisals <p>To ensure ongoing compliance, 5 personnel files will be audited quarterly to ensure that annual performance evaluations are completed according Indiana licensure certification requirements. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and are approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file</p>	

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S000542	<p>Director of Nursing, on 8-8-2014 at 11:30 AM, Employee N indicated the employees should have had a performance evaluation annual, but none was performed. The purpose of the annual evaluation is to evaluate the employees' competency to deliver care pursuant to agency policies and accepted standards of health care delivery. If no annual supervisory visit was conducted, and no performance appraisal completed, it cannot be determined these employees were consistently delivering care safely and competently to agency patients.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record review and interview, the registered nurse failed to revise the plan of care for a change in diagnosis for 1 of 12 clinical records reviewed (#1) with the potential to affect all agency patients receiving skilled nursing services.</p> <p>Findings included:</p>	S000542	<p>review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all registered nurse staff regarding professional expectations as they relate to the responsibility to update and revise the plan of care was performed at the 8/14/14 mandatory staff meeting. This re-education was completed by the Director of Nursing/Director of Professional Services on 8/14/14.</p>	08/14/2014

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	<p>1. Clinical record number #1, start of care date 12-20-2013, included a plan of care established by the physician for the certification period 4-19-014 through 6-17-2014.</p> <p>At start of care on 12-20-2013, medications included Warfarin 4 mg (milligram) daily. By physician order Warfarin was discontinued on 1-3-2014. Warfarin was removed from the medication profile. The plan of care for the 2nd certification period of 2-18-2014 to 4-18-2014 continued to list "Encounter Long-Term Use Anticoagulant" as a diagnosis. The plan of care for the 3rd certification period of 4-19-2014 to 6-17-2014 continued to list "Encounter Long-Term Use Anticoagulant" as a diagnosis.</p> <p>2. The Administrator and DON agreed during exit conference on 8-8-2014 at 4 PM the plans of care established for the 2nd and 3rd certification periods for patient #1 (after the Warfarin had been discontinued on 1-3-2014) should have been revised to remove the diagnosis of "Encounter Long-Term Use of Anticoagulant" as an other diagnosis.</p>		<p>Continued re-education of all registered nurse staff on the requirements as they relate to the responsibility to update and revise the plan of care including revising the diagnosis. Re-education to be completed by DPS by 8/22/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC at the start of care, recertification and resumption of care to ensure proper establishment of the POC, including revision of diagnosis.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal</p>				

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