

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2013
NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725		
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G000000	<p>This was a federal home health complaint investigation survey.</p> <p>Complaint # IN00113843 - Substantiated: Federal deficiencies related to the allegations are cited.</p> <p>Survey Dates: 4-23-13, 4-24-13, 4-25-13, &amp; 4-29-13 and 4-30-13 &amp; 5-1-13</p> <p>Facility #: 005940</p> <p>Medicaid Vendor #: 100265610A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency census: 250 skilled, 0 home health aide only, 0 personal services</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 8, 2013</p>	G000000	<p>The submission of this Plan of Correction does not indicate an admission by Care One Home Health that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the patients of Care One Home Health. This Home Health Agency recognized it's obligation to provide legally and medically necessary care and services to its patients in an economic and efficient manner. Care One Home Health hereby maintains it is in substantial compliance with the requirements of participation for home health agencies. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this agency. It is thus submitted as a matter of statute only.</p>		

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

TITLE

(X6) DATE

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

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and services had been provided as ordered by the physician in 6 (#s 3, 5, 6, 9, 12, and 15) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 4-8-13 to 6-6-13 that included an order for an evaluation by the speech language pathologist (SLP). The plan of care states, "ST [speech therapy]: 1w1 [one time per week for 1 week] (Eval only)."</p> <p>A. The record evidenced documentation the SLP had completed the evaluation on 4-9-13 and had provided additional speech therapy services on 4-10-13 and 4-16-13. The record failed to include an order to provide the additional speech therapy visits.</p>	G000158	<p>The agency has completely overhauled processes for timely securing of physician orders, filing, etc. The Therapy Manager has implemented new processes for checking and auditing orders for each discipline at each office. The agency will send all evaluations to the physician separately to expedite the process. The orders received by the physician on this incident, dated 3.5.13, were correct and were followed by the admitting RN. On 3.7.13, the RN Wound Consultant called in to provide recommendations for treatment. New orders were obtained from the physician and followed appropriately. When the plan of care was coded by the agency, the coders inadvertently included only the orders accepted on 3.7.13, and not the original orders obtained on 3.5.13, thus creating the discrepancy. All appropriate office personnel will be in-serviced on the new procedure of securing timely physician orders and filing, by the Administrator or designee. Both coders were in-serviced by the Administrator on 5.13.13 related to always coding in "real time" and including all orders obtained</p>	05/30/2013	

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	<p>B. The supervising nurse, employee B, stated, on 4-29-13 at 3:30 PM, "The evaluation is supposed to be sent to the physician for signature for the additional visits. It was not done."</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 3-31-13 to 5-29-13 that states, "MSS [medical social services] 1 w 1 MSW [medical social worker] to eval."</p> <p>A. The agency's February 2007 "Acceptance of Clients" policy number 3001 states, "If to be evaluated, calls and schedules visit with applicant or applicant's family within 48 hours of approved referral (MD order and all needed information completed.)"</p> <p>B. The record failed to evidence the MSS evaluation had been completed within 48 hours as required by agency policy.</p> <p>C. The supervising nurse, employee B, indicated, on 5-2-13 at 12:45 PM, the MSS evaluation had not been completed within 48 hours.</p> <p>3. Clinical record number 6 included a skilled nurse visit note, signed and dated by employee N, a registered nurse, on</p>		<p>in the 5-day window. All Social Workers will be in-serviced by the Administrator or designee related to the 48-hour standard/policy and procedures for evaluation. Clinical managers or designee will audit 10% of MSW evaluation orders for 3 months and then PRN as needed, to ensure compliance. All therapists will be in-serviced by the Therapy Manager or designee related to the 48 hour policy for all evaluations, obtaining orders for evaluations and additional visits as well as discharge orders prior to discharge. Therapy Manager or designee will audit therapy notes and new orders for timeliness and completion; she will audit 50% of all therapy notes, discharge orders for 30 days, then 10% for 3 months and then PRN as needed, to ensure compliance. All RN's will be in-serviced by the Administrator or designee related to obtaining orders for all labs. Clinical Managers will audit 100% of all lab orders for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. The Clinical Managers will physically match the lab results received to the order, thus ensuring there is an order for the lab. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying orders for wound treatments. Clinical Managers will audit 100% of all lab orders for 30 days, then 10% for 3 months and then PRN</p>				

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	<p>3-28-13, that evidenced the nurse had completed a venipuncture to obtain blood for a laboratory test.</p> <p>A. The record failed to evidence an order from the physician for the blood draw.</p> <p>B. The branch clinical manager, employee O, a registered nurse, stated, on 4-25-13 at 11:00 AM, "There is not an order for the blood draw."</p> <p>4. Clinical record number 9 included an occupational therapy (OT) evaluation and plan of care dated 6-7-12 and signed by the physician on 7-17-12 that states, "Frequency and Duration: 1w1 2w6 [two times per week for 6 weeks]."</p> <p>A. The record evidenced the evaluation and only 2 additional visits had been provided. The record failed to evidence any additional OT visits had been provided after 6-15-12.</p> <p>B. The supervising nurse, employee B, stated, on 4-25-13 at 12:40 PM, "The service record does not show any additional visits were provided. The patient's [significant other] had called and stated the patient did not want any more therapy visits. The therapist was notified but the therapist did not get an order to</p>		<p>as needed to ensure compliance. All therapists will be in-serviced by the Therapy manager or designee related to the 48 hour policy for all evaluations, obtaining orders for evaluations and additional visits as well as discharge orders prior to discharge. Administrator or designee will audit 50% of all charts coded in "real time" and including all orders obtained in the 5-day window. The Administrator or designee will audit 50% of charts coded for "real time" for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. Date of completion: 5.30.13</p>	

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	<p>discontinue the visits. There is no order to discontinue the OT visits."</p> <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 3-5-13 to 5-3-13 that states, "SN [skilled nurse] to perform / instruct wound care of LLE [left lower extremity] cellulitis. Frequency 2 times a week for 3 weeks. Ordered care as follows: Cleanse the area with antibacterial soap and water, pat dry, apply a Gelocast Unna Boot and cover with Coban. Reevaluate at end of week 3 for use of a double layered Size F Tubigrip for maintenance. Maintenance on the RLE [right lower extremity] will be double layer of Size F Tubigrip."</p> <p>A. The record included the start of care skilled nurse visit note dated 3-5-13 that states, "SN [skilled nurse] cleansed LLE with antimicrobial soap and water, patted dry, applied the mepilex AG and wrapped leg with kerlix and secured with tubigrip size F single layer." The note failed to evidence the dressing change had been provided in accordance with the plan of care.</p> <p>B. A SN visit note dated 3-7-13 failed to evidence any dressing change had been completed.</p>						

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	<p>C. The record failed to evidence any contact with the physician to reevaluate the left lower extremity for use of a double layered Tubigrip stocking as per the plan of care.</p> <p>1.) SN visit notes, dated 3-26-13, 3-28-13, 4-2-13, and 4-9-13, evidenced the SN had continued to apply the Unna Boot.</p> <p>2.) SN visit notes, dated 4-15-13 and 4-23-13, evidenced the SN had applied TED hose to both lower extremities. The record failed to include an order for the use of the TED hose.</p> <p>6. Clinical record number 15 included a plan of care established by the physician for the certification period 3-14-13 to 5-12-13 that states, "PT 1w1. Physical Therapy to evaluate to established HEP [home exercise program]."</p> <p>A. The agency's February 2007 "Acceptance of Clients" policy number 3001 states, "If to be evaluated, calls and schedules visit with applicant or applicant's family within 48 hours of approved referral (MD order and all needed information completed.)"</p> <p>B. The record failed to evidence a physical therapy evaluation had been</p>						

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	<p>completed within 48 hours of the order.</p> <p>C. The supervising nurse, employee B, indicated, on 4-30-13 at 12:05 PM, the physical therapy evaluation had not been completed within 48 hours as required by agency policy.</p> <p>7. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients: . . . Following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>				

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G000170	<p><b>484.30</b> <b>SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had provided treatments in accordance with the plan of care in 2 (#s 6 and 12) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 6 included a skilled nurse visit note, signed and dated by employee N, a registered nurse, on 3-28-13, that evidenced the nurse had completed a venipuncture to obtain blood for a laboratory test. <ul style="list-style-type: none"> <li>A. The record failed to evidence an order from the physician for the blood draw.</li> <li>B. The branch clinical manager, employee O, a registered nurse, stated, on 4-25-13 at 11:00 AM, "There is not an order for the blood draw."</li> </ul> </li> <li>Clinical record number 12 included a plan of care established by the physician for the certification period 3-5-13 to 5-3-13 that states, "SN to perform /</li> </ol>	G000170	The orders received by the physician on this incident, dated 3.5.13, were correct and were followed by the admitting RN. On 3.7.13, the RN Wound Consultant called in to provide recommendations for treatment. New orders were obtained from the physician and followed appropriately. When the plan of care was coded by the agency, the coders inadvertently included only the orders accepted on 3.7.13, and not the original orders obtained on 3.5.13, thus creating the discrepancy. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying all orders for wounds and labs and to furnish skilled nursing services in accordance with the plan of care. Clinical Managers will audit 100% of all lab orders X 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. The Clinical Managers will physically match the lab results received to the order, thus ensuring there is an order for the lab. Both Coders were in-serviced by the Administrator related to always coding in "real time" and including all orders obtained in a 5-day window. Administrator or designee will audit 50% of charts coded for "real time" for 30 days, then 10% for 3 months and PRN	05/30/2013			

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	<p>instruct wound care of LLE [left lower extremity] cellulitis. Frequency 2 times a week for 3 weeks. Ordered care as follows: Cleanse the area with antibacterial soap and water, pat dry, apply a Gelocast Unna Boot and cover with Coban. Reevaluate at end of week 3 for use of a double layered Size F Tubigrip for maintenance. Maintenance on the RLE [right lower extremity] will be double layer of Size F Tubigrip."</p> <p>A. The record included the start of care skilled nurse visit note dated 3-5-13 that states, "SN [skilled nurse] cleansed LLE with antimicrobial soap and water, patted dry, applied the mepilex AG and wrapped leg with kerlix and secured with tubigrip size F single layer." The note failed to evidence the dressing change had been provided in accordance with the plan of care.</p> <p>B. A SN visit note dated 3-7-13 failed to evidence any dressing change had been completed.</p> <p>C. The record failed to evidence any contact with the physician to reevaluate the left lower extremity for use of a double layered Tubigrip stocking as per the plan of care.</p> <p>1.) SN visit notes, dated 3-26-13,</p>		as needed to ensure compliance. Date of completion: 5.30.13				

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	<p>3-28-13, 4-2-13, and 4-9-13, evidenced the SN had continued to apply the Unna Boot.</p> <p>2.) SN visit notes, dated 4-15-13 and 4-23-13, evidenced the SN had applied TED hose to both lower extremities.</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients: . . . Following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>			

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G000211	<p><b>484.36(b)(1)</b> <b>COMPETENCY EVALUATION &amp; IN-SERVICE TRAI</b> An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph. Based on personnel file review and interview, the agency failed to ensure home health aides had completed a competency evaluation program that addressed all of the required subject areas in 1 (file C) of 3 home health aide files reviewed creating the potential to affect all of the agency's current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file C evidenced the individual had been hired on 8-22-11 to provide home health aide services on behalf of the agency. The file included a competency evaluation dated 8-25-11. The competency evaluation failed to evidence the aide had been evaluated for the competent performance of vital signs and urinary catheter care.</li> <li>2. The supervising nurse, employee B, indicated, on 5-1-13 at 10:45 AM, personnel file C did not evidence the individual had been evaluated for the competent performance of vital signs or</li> </ol>	G000211	HHA "C" was removed from patient care on 5.2.13, and the Clinical Manager completed a comprehensive evaluation of vital signs and urinary catheter care; this was documented and placed in her personnel file. All other HHA's were found to be in compliance. Will have a competency evaluation for all care conducted by a contracted individual, prior to release to the field. Effective 5.8.13, all newly hired HHA's will have a competency evaluation for all care conducted by a contracted individual, prior to release to field. Administrator in-serviced all Clinical Managers on 5.14.13 related to the importance of the competency evaluation being checked off for all HHA's, prior to release to the field. Administrator will audit 100% of newly hired HHA's for competency and in-service training documentation to ensure compliance for 3 months and PRN as needed to ensure compliance. Date of Completion: 5.30.13	05/30/2013			

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	urinary catheter care.			

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G000213	<p><b>484.36(b)(2)(i) COMPETENCY EVALUATION &amp; IN-SERVICE TRAI</b> The competency evaluation must address each of the subjects listed in paragraphs (a) (1)(ii) through (xiii) of this section.</p> <p>Based on personnel file review and interview, the agency failed to ensure home health aides had completed a competency evaluation program that addressed all of the required subject areas in 1 (file C) of 3 home health aide files reviewed creating the potential to affect all of the agency's current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Personnel file C evidenced the individual had been hired on 8-22-11 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered on 8-25-11. The competency evaluation failed to evidence the aide had been evaluated for the competent performance of vital signs as required by 42 CFR 484.36(a)(iii) and urinary catheter care as a part of toileting and elimination as required by 42 CFR 484.36(a)(ix)(F).</li> <li>The supervising nurse, employee B, indicated, on 5-1-13 at 10:45 AM, personnel file C did not evidence the</li> </ol>	G000213	<p>HHA "C" was removed from patient care on 5.2.13, and the Clinical Manager completed a comprehensive evaluation of vital signs and urinary catheter care; this was documented and placed in her personnel file. All other HHA's were found to be in compliance. Will have a competency evaluation for all care conducted by a contracted individual, prior to release to the field. Effective 5.8.13, all newly hired HHA's will have a competency evaluation for all care conducted by a contracted individual, prior to release to field. Administrator in-serviced all Clinical Managers on 5.14.13 related to the importance of the competency evaluation being checked off for all HHA's, prior to release to the field. Administrator will audit 100% of newly hired HHA's for competency and in-service training documentation to ensure compliance for 3 months and PRN as needed to ensure compliance. Date of Completion: 5.30.13</p>	05/30/2013

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N000000	<p>individual had been evaluated for the competent performance of vital signs or urinary catheter care.</p> <p>This was a State home health complaint investigation survey.</p> <p>Complaint # IN00113843 - Substantiated: State deficiencies related to the allegations are cited.</p> <p>Survey Dates: 4-23-13, 4-24-13, 4-25-13, &amp; 4-29-13 and 4-30-13 &amp; 5-1-13</p> <p>Facility #: 005940</p> <p>Medicaid Vendor #: 100265610A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency census: 250 skilled, 0 home health aide only, 0 personal services</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 8, 2013</p>	N000000	The submission of this Plan of Correction does not indicate an admission by Care One Home Health that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the patients of Care One Home Health. This Home Health Agency recognized it's obligation to provide legally and medically necessary care and services to its patients in an economic and efficient manner. Care One Home Health hereby maintains it is in substantial compliance with the requirements of participation for home health agencies. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this agency. It is thus submitted as a matter of statute only.		

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N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and services had been provided as ordered by the physician in 6 (#s 3, 5, 6, 9, 12, and 15) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care established by the physician for the certification period 4-8-13 to 6-6-13 that included an order for an evaluation by the speech language pathologist (SLP). The plan of care states, "ST [speech therapy]: 1w1 [one time per week for 1 week] (Eval only)."</p> <p>A. The record evidenced documentation the SLP had completed the evaluation on 4-9-13 and had provided additional speech therapy services on 4-10-13 and 4-16-13. The record failed to include an order to provide the additional speech therapy visits.</p>	N000522	<p>The agency has completely overhauled processes for timely securing of physician orders, filing, etc. The Therapy Manager has implemented new processes for checking and auditing orders for each discipline at each office. The agency will send all evaluations to the physician separately to expedite the process. The orders received by the physician on this incident, dated 3.5.13, were correct and were followed by the admitting RN. On 3.7.13, the RN Wound Consultant called in to provide recommendations for treatment. New orders were obtained from the physician and followed appropriately. When the plan of care was coded by the agency, the coders inadvertently included only the orders accepted on 3.7.13, and not the original orders obtained on 3.5.13, thus creating the discrepancy. All appropriate office personnel will be in-serviced on the new procedure of securing timely physician orders and filing, by the Administrator or designee. Both coders were in-serviced by the Administrator on 5.13.13 related to always coding in "real time" and including all orders obtained</p>	05/30/2013	

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	<p>B. The supervising nurse, employee B, stated, on 4-29-13 at 3:30 PM, "The evaluation is supposed to be sent to the physician for signature for the additional visits. It was not done."</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 3-31-13 to 5-29-13 that states, "MSS [medical social services] 1 w 1 MSW [medical social worker] to eval."</p> <p>A. The agency's February 2007 "Acceptance of Clients" policy number 3001 states, "If to be evaluated, calls and schedules visit with applicant or applicant's family within 48 hours of approved referral (MD order and all needed information completed.)"</p> <p>B. The record failed to evidence the MSS evaluation had been completed within 48 hours as required by agency policy.</p> <p>C. The supervising nurse, employee B, indicated, on 5-2-13 at 12:45 PM, the MSS evaluation had not been completed within 48 hours.</p> <p>3. Clinical record number 6 included a skilled nurse visit note, signed and dated by employee N, a registered nurse, on</p>		<p>in the 5-day window. All Social Workers will be in-serviced by the Administrator or designee related to the 48-hour standard/policy and procedures for evaluation. Clinical managers or designee will audit 10% of MSW evaluation orders for 3 months and then PRN as needed, to ensure compliance. All therapists will be in-serviced by the Therapy Manager or designee related to the 48 hour policy for all evaluations, obtaining orders for evaluations and additional visits as well as discharge orders prior to discharge. Therapy Manager or designee will audit therapy notes and new orders for timeliness and completion; she will audit 50% of all therapy notes, discharge orders for 30 days, then 10% for 3 months and then PRN as needed, to ensure compliance. All RN's will be in-serviced by the Administrator or designee related to obtaining orders for all labs. Clinical Managers will audit 100% of all lab orders for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. The Clinical Managers will physically match the lab results received to the order, thus ensuring there is an order for the lab. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying orders for wound treatments. Clinical Managers will audit 100% of all lab orders for 30 days, then 10% for 3 months and then PRN</p>				

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	<p>3-28-13, that evidenced the nurse had completed a venipuncture to obtain blood for a laboratory test.</p> <p>A. The record failed to evidence an order from the physician for the blood draw.</p> <p>B. The branch clinical manager, employee O, a registered nurse, stated, on 4-25-13 at 11:00 AM, "There is not an order for the blood draw."</p> <p>4. Clinical record number 9 included an occupational therapy (OT) evaluation and plan of care dated 6-7-12 and signed by the physician on 7-17-12 that states, "Frequency and Duration: 1w1 2w6 [two times per week for 6 weeks]."</p> <p>A. The record evidenced the evaluation and only 2 additional visits had been provided. The record failed to evidence any additional OT visits had been provided after 6-15-12.</p> <p>B. The supervising nurse, employee B, stated, on 4-25-13 at 12:40 PM, "The service record does not show any additional visits were provided. The patient's [significant other] had called and stated the patient did not want any more therapy visits. The therapist was notified but the therapist did not get an order to</p>		<p>as needed to ensure compliance. All therapists will be in-serviced by the Therapy manager or designee related to the 48 hour policy for all evaluations, obtaining orders for evaluations and additional visits as well as discharge orders prior to discharge. Administrator or designee will audit 50% of all charts coded in "real time" and including all orders obtained in the 5-day window. The Administrator or designee will audit 50% of charts coded for "real time" for 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. Date of completion: 5.30.13</p>				

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	<p>discontinue the visits. There is no order to discontinue the OT visits."</p> <p>5. Clinical record number 12 included a plan of care established by the physician for the certification period 3-5-13 to 5-3-13 that states, "SN [skilled nurse] to perform / instruct wound care of LLE [left lower extremity] cellulitis. Frequency 2 times a week for 3 weeks. Ordered care as follows: Cleanse the area with antibacterial soap and water, pat dry, apply a Gelocast Unna Boot and cover with Coban. Reevaluate at end of week 3 for use of a double layered Size F Tubigrip for maintenance. Maintenance on the RLE [right lower extremity] will be double layer of Size F Tubigrip."</p> <p>A. The record included the start of care skilled nurse visit note dated 3-5-13 that states, "SN [skilled nurse] cleansed LLE with antimicrobial soap and water, patted dry, applied the mepilex AG and wrapped leg with kerlix and secured with tubigrip size F single layer." The note failed to evidence the dressing change had been provided in accordance with the plan of care.</p> <p>B. A SN visit note dated 3-7-13 failed to evidence any dressing change had been completed.</p>			

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	<p>C. The record failed to evidence any contact with the physician to reevaluate the left lower extremity for use of a double layered Tubigrip stocking as per the plan of care.</p> <p>1.) SN visit notes, dated 3-26-13, 3-28-13, 4-2-13, and 4-9-13, evidenced the SN had continued to apply the Unna Boot.</p> <p>2.) SN visit notes, dated 4-15-13 and 4-23-13, evidenced the SN had applied TED hose to both lower extremities. The record failed to include an order for the use of the TED hose.</p> <p>6. Clinical record number 15 included a plan of care established by the physician for the certification period 3-14-13 to 5-12-13 that states, "PT 1w1. Physical Therapy to evaluate to established HEP [home exercise program]."</p> <p>A. The agency's February 2007 "Acceptance of Clients" policy number 3001 states, "If to be evaluated, calls and schedules visit with applicant or applicant's family within 48 hours of approved referral (MD order and all needed information completed.)"</p> <p>B. The record failed to evidence a physical therapy evaluation had been</p>						

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	<p>completed within 48 hours of the order.</p> <p>C. The supervising nurse, employee B, indicated, on 4-30-13 at 12:05 PM, the physical therapy evaluation had not been completed within 48 hours as required by agency policy.</p> <p>7. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients: . . . Following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>				

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N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had provided treatments in accordance with the plan of care in 2 (#s 6 and 12) of 16 records reviewed creating the potential to affect all of the agency's 250 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a skilled nurse visit note, signed and dated by employee N, a registered nurse, on 3-28-13, that evidenced the nurse had completed a venipuncture to obtain blood for a laboratory test.</p> <p>A. The record failed to evidence an order from the physician for the blood draw.</p> <p>B. The branch clinical manager, employee O, a registered nurse, stated, on 4-25-13 at 11:00 AM, "There is not an order for the blood draw."</p> <p>2. Clinical record number 12 included a</p>	N000537	The orders received by the physician on this incident, dated 3.5.13, were correct and were followed by the admitting RN. On 3.7.13, the RN Wound Consultant called in to provide recommendations for treatment. New orders were obtained from the physician and followed appropriately. When the plan of care was coded by the agency, the coders inadvertently included only the orders accepted on 3.7.13, and not the original orders obtained on 3.5.13, thus creating the discrepancy. All RN's will be in-serviced by the Administrator or designee related to obtaining and clarifying all orders for wounds and labs and to furnish skilled nursing services in accordance with the plan of care. Clinical Managers will audit 100% of all lab orders X 30 days, then 10% for 3 months and then PRN as needed to ensure compliance. The Clinical Managers will physically match the lab results received to the order, thus ensuring there is an order for the lab. Both Coders were in-serviced by the Administrator related to always coding in "real time" and including all orders obtained in a 5-day window. Administrator or	05/30/2013			

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	<p>plan of care established by the physician for the certification period 3-5-13 to 5-3-13 that states, "SN to perform / instruct wound care of LLE [left lower extremity] cellulitis. Frequency 2 times a week for 3 weeks. Ordered care as follows: Cleanse the area with antibacterial soap and water, pat dry, apply a Gelocast Unna Boot and cover with Coban. Reevaluate at end of week 3 for use of a double layered Size F Tubigrip for maintenance. Maintenance on the RLE [right lower extremity] will be double layer of Size F Tubigrip."</p> <p>A. The record included the start of care skilled nurse visit note dated 3-5-13 that states, "SN [skilled nurse] cleansed LLE with antimicrobial soap and water, patted dry, applied the mepilex AG and wrapped leg with kerlix and secured with tubigrip size F single layer." The note failed to evidence the dressing change had been provided in accordance with the plan of care.</p> <p>B. A SN visit note dated 3-7-13 failed to evidence any dressing change had been completed.</p> <p>C. The record failed to evidence any contact with the physician to reevaluate the left lower extremity for use of a double layered Tubigrip stocking as per</p>		<p>designee will audit 50% of charts coded for "real time" for 30 days, then 10% for 3 months and PRN as needed to ensure compliance. Date of completion: 5.30.13</p>		

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	<p>the plan of care.</p> <p>1.) SN visit notes, dated 3-26-13, 3-28-13, 4-2-13, and 4-9-13, evidenced the SN had continued to apply the Unna Boot.</p> <p>2.) SN visit notes, dated 4-15-13 and 4-23-13, evidenced the SN had applied TED hose to both lower extremities.</p> <p>3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients: . . . Following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>						

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N000596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file review and interview, the agency failed to ensure home health aides had completed a competency evaluation program that addressed all of the required subject areas in 1 (file C) of 3 home health aide files reviewed creating the potential to affect all of the agency's current patients that receive home health aide services.</p> <p>The findings include:</p> <p>1. Personnel file C evidenced the individual had been hired on 8-22-11 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered on 8-25-11. The competency evaluation failed to evidence the aide had been evaluated for the competent performance of vital signs as required by 410 IAC 17-14-1 (h)(3) and urinary catheter care as a part of toileting</p>	N000596	HHA "C" was removed from patient care on 5.2.13, and the Clinical Manager completed a comprehensive evaluation of vital signs and urinary catheter care; this was documented and placed in her personnel file. All other HHA's were found to be in compliance. Will have a competency evaluation for all care conducted by a contracted individual, prior to release to the field. Effective 5.8.13, all newly hired HHA's will have a competency evaluation for all care conducted by a contracted individual, prior to release to field. Administrator in-serviced all Clinical Managers on 5.14.13 related to the importance of the competency evaluation being checked off for all HHA's, prior to release to the field. Administrator will audit 100% of newly hired HHA's for competency and in-service training documentation to ensure compliance for 3 months and PRN as needed to ensure compliance. Date of	05/30/2013			

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	and elimination as required by 410 IAC 17-14-1 (h)(9)(F).  2. The supervising nurse, employee B, indicated, on 5-1-13 at 10:45 AM, personnel file C did not evidence the individual had been evaluated for the competent performance of vital signs or urinary catheter care.		Completion: 5.30.13		