

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 11/04/2013	
NAME OF PROVIDER OR SUPPLIER COMFORCARE HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 11555 NORTH MERIDIAN STREET, SUITE 100 CARMEL, IN 46032			
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G000000	<p>This was a federal home health initial certification survey which resulted in an extended survey on 10/31/13.</p> <p>Facility provider number: 013284</p> <p>Survey dates: October 31 and November 1 and 4, 2013</p> <p>Medicaid vender number: Pending</p> <p>Surveyor: Bridget Boston, RN, Public Health Nurse Surveyor</p> <p>Unduplicated admissions: 10 (2 patients had been admitted 9/13/13, but no care had been provided)</p> <p>Clinical record review: 10</p> <p>Skilled patients: 8</p> <p>Home Visits: Zero</p> <p>ComForcare is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning November 12, 2013 through November 12, 2015 due to being found out of compliance with the Conditions of Participation 42 CFR 484.36: Home Health Aide services and 484.55: Comprehensive Assessment of Patients.</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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	Quality Review: Joyce Elder, MSN, BSN, RN November 12, 2013						

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G000102	<p>484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure patients were informed of their rights prior to the rendering of care in 1 of 8 clinical records reviewed and home health care services were provided with the potential to affect all the patients of the agency. (# 1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 1, start of care 8/23/13, included the agency's comprehensive assessment conducted by employee B on 8/23/13 and a plan of care dated 8/23/13 through 10/22/13 with orders for skilled nurse visits once a week. The record evidenced the patient received their patient rights and signed consents for the home health services on 8/28/13, 5 days after the start of care date of 8/23/13. 2. The policy titled Administrative - Admission Criteria" number 1.009.1 and dated May 2013 stated, "Prior to the initiation of services the RN will ensure that the client or their legal representative receives a written notice concerning all 	G000102	The Director of Nursing will in-service clinical staff on policy 1.009.1. The administrator will review 100% of the consents at start of care as part of the quality assurance process for the next 30 days. 10%, with a minimum of 5 charts, will be audited quarterly to ensure ongoing compliance. The administrator is responsible for compliance.	11/20/2013			

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	<p>policies governing patient rights."</p> <p>3. On 11/4/13 at 3:40 PM, during record review, employee B indicated the process was to review the patient rights and obtain their signature and consent for services before rendering care.</p>			

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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 review and interview, the agency failed to ensure visits were made as ordered on the plan of care established by a doctor of medicine in 6 of 8 records reviewed in which skilled nurse services were provided creating the potential to affect new agency's patients. (# 1, 2, 3, 4, 6, and 9)</p> <p>The findings include:</p> <p>1. Clinical record 1, start of care (SOC) 8/23/13, evidenced a plan of care dated 8/23/13 through 10/22/13 with orders for skilled nurse (SN) visits once a week for medication set up and twice a week for education on the maintenance and use of MACE (cecostomy) and proper technique to reduce infection for 8 weeks. The record failed to evidence a skilled nurse visit was made during week one and week eight of the certification period.</p> <p>A. The record included skilled nurse visits notes dated 8/28/13 and 8/30/13 that failed to evidence medication set up was performed as ordered, an assessment of the patient's skin integrity and</p>	G000158	The Director of Nursing will in-service clinical staff on completing the Plan of Care properly. Including frequency and duration of services with the date the services are to begin and the company work week. Review the start of care date is the day that care was performed. Education to clinical staff on documentation of care provided to show following plan of care. Any changes to the plan of care will be communicated to the ordering physician. The Administrator is responsible to ensure compliance is maintained.	11/20/2013			

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	<p>genitourinary system, and the patient's response to the education provided.</p> <p>B. The record evidenced two skilled nurse visits were conducted during week 3 of the certification period on 9/3/13 and 9/6/13. Neither skilled nurse visit note evidenced documentation medication set up was performed as ordered and the patient's response to education.</p> <p>C. The record evidenced two skilled nurse visits were conducted during week 4 of the certification period on 9/10/13 and 9/13/13. Neither skilled nurse note visit evidenced an assessment of the patient's skin integrity and genitourinary system and the patient's response to the education provided.</p> <p>2. Clinical record #2, SOC 8/23/13, included a plan of care the certification period 8/23/13 through 10/23/13 with orders for SN visits 1 visit weekly and aide services twice a week for 8 weeks. The record failed to evidence any SN visit nor any home health aide visits occurred the first week of the certification period dated 8/23/13 to 8/25/13. The first visit made was on 8/28/13.</p> <p>3. Clinical record #3, SOC 8/24/13, included a plan of care for the certification period 8/24/13 through</p>						

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	<p>10/24/13 with orders for SN visits 1 visit weekly for 8 weeks. The record failed to evidence any SN visits occurred the first week of the certification period dated 8/24/13 to to 8/25/13. The first visit made was on 8/28/13.</p> <p>4. Clinical record #4, SOC 8/29/13, included a plan of care the certification period 8/29/13 through 10/28/13 with orders for SN visits 1 visit weekly for 8 weeks for medication set up and diabetes education. The record failed to evidence any SN visit occurred the first week of the certification period dated 8/29/13 to 9/1/13. The first visit made was on 9/5/13.</p> <p>5. Clinical record # 6, start of care 9/12/13, included a plan of care the certification period 9/12/13 through 11/11/13 with orders for SN visits 1 visit weekly for 8 weeks to preset the patient's medications. The record failed to evidence any care was provided the first week of the certification period dated 9/12/13 to 9/14/13. The first visit made was on 9/16/13.</p> <p>6. Clinical record # 9, start of care 9/16/13, included a plan of care the certification period 9/16/13 through 11/15/13 with orders for SN visits 1 visit weekly for 8 weeks for education for the</p>			

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	<p>diagnosis and management of diabetes and hypertension. The record failed to evidence any care was provided the first week of the certification period dated 9/16/13 to 9/22/13. The first visit made was on 9/27/13.</p> <p>7. On 11/4/13 at 3:40 PM, employee B indicated the first visit to the home was the skilled nurse to complete the comprehensive assessment and then care was not provided until the agency received the plan of care with the signature of the physician. She indicated no care was rendered during the assessment visits.</p>						

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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 interview, the agency failed to ensure the plan of care included the instructions for the monitoring of medications that require therapeutic monitoring via blood levels or who was monitoring the patient's blood levels in 1 of 5 records reviewed of patients that received skilled nurse services and preset of their medications with the potential to affect all patients that take medications that require therapeutic blood level monitoring. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record # 6, start of care 9/12/13 included a plan of care dated 9/12/13 through 11/1/13 with orders for the skilled nurse to preset the patient's medications weekly for 8 weeks. The plan of care did not include the patient's medications and stated, "See attached." The medication profile included the medication Digoxin 125 microgram to be</p>	G000159	<p>Clinicians will be educated that all medications will be included on the plan of care and medication profile to include frequency, dosage, and administration route. Clinicians educated on high risk drugs that require regular monitoring and the process for documenting who is responsible for monitoring. 100% of the charts will be checked by the DON for 30 days and 10% thereafter for evidence that all medications including route, dosage and frequency are included on the medication profile and plan of care and that high risk drugs are being monitored properly. The Director of Nursing is responsible for compliance.</p>	11/20/2013			

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	<p>taken once daily. [Digoxin requires monitoring of blood levels for therapeutic dosing.] The record failed to evidence who was monitoring the patient's Digoxin levels.</p> <p>2. On 11/4/13 at 1:27 PM, during record review, employee B indicated she was not aware of whom was monitoring the patients Digoxin levels if anyone.</p>			

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G000202	<p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on personnel file, clinical record, and policy review and interview, it was determined the agency failed to ensure home health aides had completed a competency evaluation program that addressed all of the required subject areas in 1 of 1 file, the only home health aide employed, creating the potential to affect all of the agency's current patients that receive home health aide services (See G 211); failed to ensure the home health aide met the competency evaluation requirement for 1 of 1 aide employed by the agency with the potential to affect the one patient who received home health aide services (See G 212); failed to ensure home health aides had completed a competency evaluation program that addressed all of the required subject areas in 1 of 1 home health aide files reviewed creating the potential to affect all of the agency's current patients that receive home health aide services (See G 213); and failed to ensure the registered nurse completed an on-site supervisory visit of the home health aide every 14 days in 1 of 1 active records reviewed of patients who received skilled nurse and home health aide services longer than 14 days with the potential to affect all the patients of the agency receiving home health aide services (See G 229).</p>	G000202	<p>The Director of Nursing will ensure that each home health aide completes a competency evaluation before providing patient care. The aide must pass a written competency exam and a RN will complete a skills checklist per standard with direct observation of vital signs, appropriate and safe techniques in personal hygiene and grooming to include; bed bath, sponge, tub or shower bath, shampoo, nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, and normal range of motion and positioning. The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested third party. A supervisory visit will be made every 14 days by a RN for patients receiving skilled services. 100% of employee files will be audited to ensure the deficiency is corrected and complacency is maintained.</p>	11/20/2013			

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	The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.36 Home Health Aide Services.			
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G000211	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>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.</p> <p>Based on personnel file, clinical record, and policy 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 E) of 1 home health aide file reviewed, the only home health aide employed, 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 E evidenced the individual had been hired on 8/12/13 to provide home health aide services on behalf of the agency. The file included a competency evaluation dated 8/12/13. The competency evaluation failed to evidence the aide had been evaluated for the competent performance of vital signs, appropriate and safe techniques in personal hygiene and grooming that included a bed bath, nail and skin care, toileting and elimination, safe transfer techniques and ambulation, and normal</p>	G000211	<p>The Director of Nursing will ensure that each home health aide completes a competency evaluation before providing patient care. The aide must pass a written competency exam and a RN will complete a skills checklist per standard with direct observation of vital signs, appropriate and safe techniques in personal hygiene and grooming to include; bed bath, sponge, tub or shower bath, shampoo, nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, and normal range of motion and positioning. The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested third party 100% of employee files will be audited to ensure the deficiency is corrected and complacency is maintained.</p>	11/20/2013			

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	<p>range of motion and positioning.</p> <p>Clinical record # 2, start of care 8/23/13, included documentation employee E provided services on August 28 and 30; September 3, 6, 10, 13, 17, 20, 24, and 27; and October 1, 4, 8, and 11, 2013.</p> <p>2. The supervising nurse, employee B, indicated, on 10/31/13 at 11:36 AM during the entrance conference, that employee E was only evaluated for the tasks required to care for patient # 2. She indicated the employee was evaluated as she performed and provided a shower, shampoo, and assisted patient # 2 to ambulate, and no other tasks were evaluated.</p> <p>3. The policy titled "Quality Management - Nursing Aide / HHA" stated, "All aide services are provided in accordance with the recognized state regulations. ... Aide Training. The aide must pass a HHA [home health aide] competency exam and a registered nurse will complete a competency assessment skills checklist with direct observation of each skill for each aide before assignment begins."</p>						

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G000212	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on personnel record, clinical record, and policy review and interview, the agency failed to ensure the home health aide met the competency evaluation requirement for 1 (file E) of 1 home health aide file reviewed, the only home health aide employed, 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 E evidenced the individual had been hired on 8/12/13 to provide home health aide services on behalf of the agency. The file included a competency evaluation dated 8/12/13. The competency evaluation failed to evidence the aide had been evaluated for the competent performance of vital signs, appropriate and safe techniques in personal hygiene and grooming that included a bed bath, nail and skin care, toileting and elimination, safe transfer techniques and ambulation, and normal range of motion and positioning.</p>	G000212	<p>The Director of Nursing will ensure that each home health aide completes a competency evaluation before providing patient care. The aide must pass a written competency exam and a RN will complete a skills checklist per standard with direct observation of vital signs, appropriate and safe techniques in personal hygiene and grooming to include; bed bath, sponge, tub or shower bath, shampoo, nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, and normal range of motion and positioning. The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested third party. 100% of employee files will be audited to ensure the deficiency is corrected and complacency is maintained.</p>	11/20/2013			

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	<p>Clinical record # 2, start of care 8/23/13, included documentation employee E provided services on August 28 and 30; September 3, 6, 10, 13, 17, 20, 24, and 27; and October 1, 4, 8, and 11, 2013.</p> <p>2. The supervising nurse, employee B, indicated, on 10/31/13 at 11:36 AM during the entrance conference, that employee E was only evaluated for the tasks required to care for patient # 2. She indicated the employee was evaluated as she performed and provided a shower, shampoo, and assisted patient # 2 to ambulate, and no other tasks were evaluated.</p> <p>3. The policy titled "Quality Management - Nursing Aide / HHA" stated, "All aide services are provided in accordance with the recognized state regulations. ... Aide Training. The aide must pass a HHA [home health aide] competency exam and a registered nurse will complete a competency assessment skills checklist with direct observation of each skill for each aide before assignment begins."</p>						

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G000213	<p>484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAI The competency evaluation must address each of the subjects listed in paragraphs (a) (1)(ii) through (xiii) of this section. Based on personnel file, clinical record, and policy 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 E) of 1 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 E evidenced the individual had been hired on 8/12/13 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered on 8/12/13. 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), appropriate and safe techniques in personal hygiene and grooming that include a bed bath, nail and skin care, and toileting and elimination as required by 42 CFR 484.36(a)(ix)(A)(D) and (F), safe transfer techniques and ambulation as</p>	G000213	The Director of Nursing will ensure that each home health aide completes a competency evaluation before providing patient care. The aide must pass a written competency exam and a RN will complete a skills checklist per standard with direct observation of vital signs, appropriate and safe techniques in personal hygiene and grooming to include; bed bath, sponge, tub or shower bath, shampoo, nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, and normal range of motion and positioning. The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested third party. 100% of employee files will be audited to ensure the deficiency is corrected and complacency is maintained.	11/20/2013			

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	<p>required by 42 CFR 484.36(x), and Normal range of motion and positioning as required by 42 CFR 4784.36(xi).</p> <p>Clinical record # 2, start of care 8/23/13, included documentation employee E provided services on August 28 and 30; September 3, 6, 10, 13, 17, 20, 24, and 27; and October 1, 4, 8, and 11, 2013.</p> <p>2. The supervising nurse, employee B, indicated, on 10/31/13 at 11:36 AM during the entrance conference, that employee E was only evaluated for the tasks required to care for patient # 2. She indicated the employee was evaluated as she performed and provided a shower, shampoo, and assisted patient # 2 to ambulate, and no other tasks were evaluated.</p> <p>3. The policy titled "Quality Management - Nursing Aide / HHA" stated, "All aide services are provided in accordance with the recognized state regulations. ... Aide Training. The aide must pass a HHA [home health aide] competency exam and a registered nurse will complete a competency assessment skills checklist with direct observation of each skill for each aide before assignment begins."</p>						

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G000229	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse completed an on-site supervisory visit of the home health aide every 14 days in 1 of 1 (patient # 2) active records reviewed of patients who received skilled nursing and home health aide services longer than 14 days with the potential to affect all the patients of the agency receiving home health aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2, start of care 8/23/13, included a plan of care for the certification period 8/23/13 to 10/22/13 with orders for skilled nurse and home health aide services. The record evidenced aide services began on 8/28/13 and continued twice a week through 10/11/13. The record failed to evidence a supervisory visit was made by the registered nurse until 9/13/13 and failed to evidence any other supervisory visits were conducted. 2. The policy with an effective date May 	G000229	<p>A supervisory visit will be made no less than every 14 days by a RN for patients receiving skilled services. A electronic scheduling system will be used to track timely supervisory visits are made. 10% of charts will be audited quarterly to ensure supervisory visits are being made within 14 days. The Director of Nursing is responsible for compliance.</p>	11/20/2013			

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	<p>2013 titled "Quality Management Nursing Aide / HHA " number 6.021.1 stated, "Home Health Aides will be supervised at least every 30 days by a RN when the aide is present in the client's home and every 14 days when the patient is receiving a skilled service."</p> <p>3. On 11/4/13 at 3::40 PM, during clinical record review, the director of clinical services indicated the supervisory visits had not been made every 14 days.</p>			

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G000330	<p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and policy review and interview, it was determined the agency failed to ensure the registered nurse made an initial assessment visit within 48 hours of referral in 4 of 10 clinical records reviewed with the potential to affect all new patients (See G 332); failed to ensure the registered nurse completed the a comprehensive assessment no later than 5 calendar days after the first billable home visit with all the required elements in 8 of 10 clinical records reviewed with the potential to</p>	G000330	<p>Administrator will train office personnel on referral documentation process to include referral source and referral date. RN will perform an initial assessment within 48 hrs of referral, 48 hrs of patient return home, or on the physician-ordered start of care date. If the initial assessment is not performed within 48 hrs, the reason will be properly documented. The RN is responsible for follow up to obtain physician order for home care. The Director of Nursing has</p>	11/20/2013			

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	<p>affect all the patients of the agency (See G 334); and failed to ensure the comprehensive reassessment included a review of all the patient's medications and an assessment for potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance in 10 of 10 clinical records reviewed of patients receiving skilled nursing services with the potential to affect all patients (See G 337).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.55: Comprehensive Assessment of Patients.</p>		<p>inserviced the staff on policy 6.019.1 "Comprehensive Assessment of Clients" and that it must be completed within 5 days of the first billable home visit. Educated staff on completing documentation to reflect the patient's current status and to not document by exception. Reviewed the company comprehensive assessment form and instructed on where to place information. For Medicaid patients, agency will use MedPass Comprehensive Assessment Forms that have OASIS items incorporated. Director of Nursing has educated the clinical staff on proper documentation to show proof a drug regimen review to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance has been performed. 100% chart review will be done for 30 days and 10% review quarterly thereafter to ensure compliance. The DON and Administrator are responsible for compliance.</p>		

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G000332	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse made an initial assessment visit within 48 hours of referral in 4 of 10 clinical records reviewed with the potential to affect all new patients. (# 1, 2, 9, and 10)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record 1, start of care 8/23/13, evidenced a verbal order dated 8/20/13 to evaluate for home health services. The record failed to evidence an initial assessment was completed within 48 hours of the verbal order for evaluation for home health services nor documentation to explain why the initial visit was late. Clinical record 2, start of care 8/23/13, evidenced a verbal order dated 8/20/13 to evaluate for home health services. The record failed to evidence an initial assessment was completed within 48 hours of the verbal order for evaluation for home health services nor documentation to explain why the initial visit was late. 	G000332	<p>Administrator will train office personnel on referral documentation process to include referral source and referral date. RN will perform an initial assessment within 48 hrs of referral, 48 hrs of patient return home, or on the physician-ordered start of care date. If the initial assessment is not performed within 48 hrs, the reason will be properly documented. The RN is responsible for follow up to obtain physician order for home care. 100% chart review will be done for 30 days and 10% review quarterly thereafter to ensure compliance. The Administrator is responsible for compliance.</p>	11/20/2013			

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	<p>3. Clinical record 9, start of care 9/16/13, evidenced a verbal order dated 9/11/13 to evaluate for home health services. The record failed to evidence an initial assessment was completed within 48 hours of the verbal order for evaluation for home health services nor documentation to explain why the initial visit was late.</p> <p>4. Clinical record 10, start of care 9/19/13, evidenced a verbal order dated 9/16/13 to evaluate for home health services. The record failed to evidence an initial assessment was completed within 48 hours of the verbal order for evaluation for home health services nor documentation to explain why the initial visit was late.</p> <p>5. The policy titled "Quality Management Comprehensive Assessment of Clients" number 6.019.1 dated May 2013 stated, "A comprehensive assessment will be performed on qualified clients at: Start of care:[sic] ... The initial assessment must be performed within 48 hours of receiving the referral, The assessment must be performed prior to the start of any services being provided."</p> <p>6. On 11/4/13 at 7 PM, during clinical record review, employee B indicated she</p>			

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	<p>did not receive verbal orders to assess the patients and was waiting on signed physician orders to return to the office before conducting an initial assessment. She indicated she was advised by a consultant to not go to assess the patient until signed physician orders were received.</p>			

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G000334	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse completed the a comprehensive assessment no later than 5 calendar days after the first billable home visit (start of care) with all the required elements in 8 (# 1, 2, 3, 4, 6, 7, 8, 9, and 10) of 10 clinical records reviewed with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care (SOC) (defined as first billable visit) 8/23/13, failed to evidence a start of care comprehensive assessment was completed with all required elements within 5 days of the first billable home visit.</p> <p>The record evidenced a plan of care dated 8/23/13 through 10/22/13 with orders for skilled nurse visits once a week for medication set up and twice a week for education on the maintenance and use of MACE (Malone antegrade continence enema -A surgical procedure used to</p>	G000334	<p>The Director of Nursing has inserviced the staff on policy 6.019.1 "Comprehensive Assessment of Clients" and that it must be completed within 5 days of the first billable home visit. Educated staff on completing documentation to reflect the patient's current status and to not document by exception. Reviewed the company comprehensive assessment form and instructed on where to place information. For Medicaid patients, agency will use MedPass Comprehensive Assessment Forms that have OASIS items incorporated. 100% chart review will be done for 30 days and 10% review quarterly thereafter to ensure compliance. The Director of Nursing is responsible for reviewing and monitoring the comprehensive assessments to ensure they are completed properly and on time.</p>	11/25/2013			

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	<p>create a continent pathway proximal to the anus that facilitates fecal evacuation using enemas) and proper technique to reduce infection for 8 weeks. The record evidenced the first day care was rendered (first billable visit) was 8/28/13.</p> <p>2. Clinical record # 2, SOC 8/23/13, failed to evidence a start of care comprehensive assessment was completed with all required elements and completed within 5 days of the first billable home visit.</p> <p>The record evidenced the first day care was rendered (first billable visit) was 8/28/13 by employee E, a home health aide.</p> <p>3. Clinical record #3, SOC 8/24/13, failed to evidence a start of care comprehensive assessment was completed with all required elements and completed within 5 days of the first billable home visit.</p> <p>The record evidenced the first day care was rendered was 8/28/13 (first billable visit) by employee B, a registered nurse. Medications were prepared for the patient during the visit.</p> <p>4. Clinical record # 4, start of care 8/29/13, failed to evidence a start of care comprehensive assessment was completed</p>						

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	<p>with all required elements and completed within 5 days of the first billable home visit.</p> <p>The record evidenced the first day care was rendered was 9/5/13 by employee B, a registered nurse. Medications were prepared for the patient during the visit.</p> <p>5. Clinical record # 6, start of care 9/12/13, failed to evidence a start of care comprehensive assessment was completed with all required elements and completed within 5 days of the first billable home visit.</p> <p>The record evidenced the first day care was rendered was 9/16/13 by employee B, a registered nurse. Medications were prepared for the patient during the visit.</p> <p>6. Clinical record # 7, start of care 9/13/13, failed to evidence a start of care comprehensive assessment was completed with all required elements and completed within 5 days of the first billable home visit. The record failed to evidence any care had been provided.</p> <p>7. Clinical record # 8, start of care 9/13/13, failed to evidence a start of care comprehensive assessment was completed</p>						

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	<p>with all required elements and completed within 5 days of the first billable home visit. The record failed to evidence any care had been provided.</p> <p>8. Clinical record # 10, start of care 9/19/13, failed to evidence a start of care comprehensive assessment was completed with all required elements and completed within 5 days of the first billable home visit.</p> <p>The record evidenced the first day care was rendered was 10/1/13. The date of the comprehensive assessment was 9/19/13</p> <p>9. The policy dated May 2013 titled "Comprehensive Assessment of Patients" stated, "The physical health component: Identification of additional health problems, ... special nutritional needs or dietary requirements and weight loss, complete pain and other symptoms assessment, ... integumentary status, including presence of any wounds, respiratory status, elimination status, ... client / family preference for treatment and concerns, ... Comprehensive Pain Assessment, History of pain and its treatment, characteristics of the pain (intensity, descriptors, pattern, location, radiation, frequency, timing, duration, quality of life, strategies that reduce pain,</p>						

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	<p>what makes it worse, goals for pain management. Other common physical symptoms - nausea, anorexia, constipation, anxiety, restlessness, dyspnea, dehydration, skin breakdown, and sleep disorders. ... Language preference ... Instructions and interventions are directed to minimizing safety risks and preventing injury. ... The clients ability to ambulate. Documentation of all functional limitations."</p> <p>10. On 11/4/13 at 3:40 PM, employee B indicated the first visit to the home was the skilled nurse to complete the comprehensive assessment and the documentation was by exception; if something was outside of normal limits / expectations, then it was to be documented. She indicated no care was rendered during the assessment visit.</p>				

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G000337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the comprehensive reassessment included a review of all the patient's medications for potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance in 10 of 10 clinical records reviewed of patients receiving skilled nursing services (#s 1 through 10) with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record # 1, start of care 8/23/13 included a comprehensive assessment dated 8/23/13 and a reassessment dated 10/22/13 completed by employee B. The record failed to evidence a medication review was performed as part of the comprehensive assessments to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p>	G000337	Director of Nursing has educated the clinical staff on proper documentation to show proof a drug regimen review to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance has been performed. 100% chart review will be done for 30 days and 10% review quarterly thereafter to ensure compliance. The DON is responsible for compliance.	11/20/2013			

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	<p>2. Clinical record # 2, SOC 8/23/13 included a comprehensive assessment dated 8/23/13 and a reassessment dated 10/19/13 completed by employee B. The record failed to evidence a medication review was performed as part of the comprehensive assessments to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>3. Clinical record # 3, start of care 8/24/13 included a comprehensive assessment dated 8/24/13 and a reassessment dated 10/22/13 completed by employee B. The record failed to evidence a medication review was performed as part of the comprehensive assessments to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>4. Clinical record # 4, start of care 8/29/13 included a comprehensive assessment dated 8/29/13 completed by employee B. The record failed to evidence a medication review was performed as part of the comprehensive assessment to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p>						

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	<p>5. Clinical record # 5, start of care 8/30/13 included a comprehensive assessment dated 8/30/13 completed by employee B. The record failed to evidence a medication review was performed as part of the comprehensive assessment to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>6. Clinical record # 6, start of care 9/12/13 included a comprehensive assessment dated 9/12/13 completed by employee B. The record failed to evidence a medication review was performed as part of the comprehensive assessment to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>7. Clinical record # 7, start of care 9/13/13 included a comprehensive assessment dated 9/13/13 completed by employee B. The record failed to evidence a medication review was performed as part of the comprehensive assessment to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>8. Clinical record # 8, start of care</p>						

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	<p>9/13/13 included a comprehensive assessment dated 9/13/13 completed by employee B. The record failed to evidence a medication review was performed as part of the comprehensive assessment to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>9. Clinical record # 9, start of care 9/16/13 included a comprehensive assessment dated 9/16/13 completed by employee B. The record failed to evidence a medication review was performed as part of the comprehensive assessment to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>10. Clinical record # 10, start of care 9/19/13 included a comprehensive assessment dated 9/19/13. The record failed to evidence a medication review was performed as part of the updated comprehensive assessments to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>11. The policy dated May 2013 titled "Medication Profile" stated, "Nursing staff check all medications a client may</p>						

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	<p>be taking to identify possible ineffectiveness, side effects, toxic effects, allergic reactions, unusual / unexpected effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. ... The medication profile will be updated at least every 60 days or more often as needed."</p> <p>12. During the record review on 11/4/13 at 3:40 PM, employee B indicated the records did not include documentation of a medication review which included all the required elements.</p>			

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N000000	<p>This was an initial home health state licensure survey.</p> <p>Facility provider number: 013284</p> <p>Survey dates: October 31 and November 1 and 4, 2013</p> <p>Medicaid vender number: Pending</p> <p>Surveyor: Bridget Boston, RN, Public Health Nurse Surveyor</p> <p>Unduplicated admissions: 10 Clinical record review: 10 Skilled patients: 8 Home Visits: Zero</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 12, 2013</p>	N000000					

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N000460	<p>410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall:</p> <p>(1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.</p> <p>Based on personnel file and interview, the agency failed to ensure personnel files included a criminal history, applied for within 3 business days of employment, as required by IC 16-27-2 for 1 (File E) of 3 files reviewed of employees who had direct patient contact.</p> <p>The findings include:</p> <p>1. Personnel file E, date of hire 8/12/13 and first patient contact 8/28/13, failed to evidence a limited criminal history from the Indiana central repository for criminal history information under IC 16-27-2 was completed within 3 days of when the employee began providing services. The file evidenced a national criminal history check was completed on 11/28/12 when the individual was hired as a personal</p>	N000460	<p>100% of employee files will be audited for compliance of having a criminal background check per requirement. The administrator is responsible for compliance. The employee had a background check performed 11/28/2012 by the owners of the home health agency. See Attachment B. Per IC 16-27-2-4 the check must be applied for not more than 3 business days after the date than an employee begins to provide services by the person that owns the home health agency. We believe the standard was met due to the background check being performed by the owners of the HHA before the employee provided patient care. Requesting tag to be deleted. Attachment B.</p>	11/20/2013			

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	<p>attendant for another company owned by the same corporation.</p> <p>2. On 11/4/13 at 7 PM, employees A and B indicated there was no further information available.</p>						

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N000462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review and interview, the agency failed to ensure personnel files included a physical exam that was completed by a physician or nurse practitioner no more than 180 days before the employee has direct patient contact for 1 (File E) of 3 files reviewed of employees who had direct patient contact with the potential to affect all patients in contact with employee E.</p> <p>The findings include:</p> <p>1. Personnel file E, date of hire 8/12/13 and first patient contact 8/28/13, failed to evidence a physical exam had been been completed by a physician or nurse practitioner and that verified the employee was free from communicable disease before contact with an agency patient. The file evidenced a physical exam was conducted on 10/8/13.</p>	N000462	100% of employee files will be audited for compliance of having a physical exam stating the employee is free of communicable diseases has been performed no more than 180 days before patient contact. The administrator is responsible for compliance.	11/20/2013			

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	2. On 11/4/13 at 7 PM, employee A and B indicated there was no further information available.			

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N000464	<p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on</p>			

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	<p>a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file review and interview, the agency failed to ensure Tuberculosis (TB) screenings with a two step Mantoux was completed upon hire when there was not a negative history of tuberculin screening or a chest x ray report available for 1 (file E) of 3 files reviewed of employees who had provided direct patient contact.</p> <p>The findings include:</p> <p>1 Personnel file E, date of hire 8/12/13 and first patient contact 8/28/13, failed to evidence a second step tuberculin test had been completed, a negative tuberculin test history, or a negative chest x-ray results. The file evidenced a tuberculin skin test, administered on 9/4/12 that was not read and a one step skin test administered on 9/6/13.</p> <p>2. On 11/4/13 at 7 PM, employees A and B indicated there was no further</p>	N000464	<p>100% of employee files will be audited by the administrator for compliance of having a two step Mantoux when there is not a negative history of TB screening. The administrator is responsible for compliance.IDR: Employee E file had a TB test performed on 9/4/2012 that was read on 9/6/2012 Attachment A. She had another on 9/4/2013, read on 9/6/2013. At the time of the survey we were unable to find the first TB test when requested. The administrator stated that the results should have been in the file provided to the surveyor. Multiple documents from multiple files had been removed by the surveyor. The test was located when putting the files back together after the surveyor left. She had placed it in another pile of documents she set aside. Please see attachment A. Requesting tag be deleted.</p>	11/20/2013

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N000494	<p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure patients were informed of their rights prior to the rendering of care in 1 of 8 clinical records reviewed and home health care services were provided with the potential to affect all the patients of the agency. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record 1, start of care 8/23/13, included the agency's comprehensive assessment conducted by employee B on 8/23/13 and a plan of care dated 8/23/13 through 10/22/13 with orders for skilled nurse visits once a week. The record evidenced the patient received their patient rights and signed consents for the</p>	N000494	The Director of Nursing will in-service clinical staff on policy 1.009.1. The administrator will review 100% of the consents at start of care as part of the quality assurance process for the next 30 days. 10%, with a minimum of 5 charts, will be audited quarterly to ensure ongoing compliance. The administrator is responsible for compliance.	11/20/2013			

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	<p>home health services on 8/28/13, 5 days after the start of care date of 8/23/13.</p> <p>2. The policy titled Administrative - Admission Criteria" number 1.009.1 and dated May 2013 stated, "Prior to the initiation of services the RN will ensure that the client or their legal representative receives a written notice concerning all policies governing patient rights."</p> <p>3. On 11/4/13 at 3:40 PM, during record review, employee B indicated the process was to review the patient rights and obtain their signature and consent for services before rendering care.</p>						

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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 review and interview, the agency failed to ensure visits were made as ordered on the plan of care established by a doctor of medicine in 6 of 8 records reviewed in which skilled nurse services were provided creating the potential to affect new agency's patients. (# 1, 2, 3, 4, 6, and 9)</p> <p>The findings include:</p> <p>1. Clinical record 1, start of care 8/23/13, evidenced a plan of care dated 8/23/13 through 10/22/13 with orders for skilled nurse (SN) visits once a week for medication set up and twice a week for education on the maintenance and use of MACE (cecostomy) and proper technique to reduce infection for 8 weeks. The record failed to evidence a skilled nurse visit was made during week one and week eight of the certification period.</p> <p>A. The record included skilled nurse visits notes dated 8/28/13 and 8/30/13 that failed to evidence medication set up was performed as ordered, an assessment of the patient's skin integrity and</p>	N000522	<p>The Director of Nursing will in-service clinical staff on completing the Plan of Care properly. Including frequency and duration of services with the date the services are to begin. Review the start of care date is the day that care was performed. Education to clinical staff on documentation of care provided to show following plan of care. Any changes to the plan of care will be communicated to the ordering physician. The Administrator is responsible to ensure compliance is maintained.</p>	11/20/2013			

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	<p>genitourinary system, and the patient's response to the education provided.</p> <p>B. The record evidenced two skilled nurse visits were conducted during week 3 of the certification period on 9/3/13 and 9/6/13. Neither skilled nurse visit note evidenced documentation medication set up was performed as ordered and the patient's response to education.</p> <p>C. The record evidenced two skilled nurse visits were conducted during week 4 of the certification period on 9/10/13 and 9/13/13. Neither skilled nurse note visit evidenced an assessment of the patient's skin integrity and genitourinary system and the patient's response to the education provided.</p> <p>2. Clinical record #2 included a plan of care the certification period 8/23/13 through 10/23/13 with orders for SN visits 1 visit weekly and aide services twice a week for 8 weeks. The record failed to evidence any SN visit nor any home health aide visits occurred the first week of the certification period dated 8/23/13 to 8/25/13. The first visit made was on 8/28/13.</p> <p>3. Clinical record #3 included a plan of care for the certification period 8/24/13 through 10/24/13 with orders for SN</p>						

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	<p>visits 1 visit weekly for 8 weeks. The record failed to evidence any SN visits occurred the first week of the certification period dated 8/24/13 to to 8/25/13. The first visit made was on 8/28/13.</p> <p>4. Clinical record #4 included a plan of care the certification period 8/29/13 through 10/28/13 with orders for SN visits 1 visit weekly for 8 weeks for medication set up and diabetes education. The record failed to evidence any SN visit occurred the first week of the certification period dated 8/29/13 to 9/1/13. The first visit made was on 9/5/13.</p> <p>5. Clinical record # 6, start of care 9/12/13, included a plan of care the certification period 9/12/13 through 11/11/13 with orders for SN visits 1 visit weekly for 8 weeks to preset the patient's medications. The record failed to evidence any care was provided the first week of the certification period dated 9/12/13 to 9/14/13. The first visit made was on 9/16/13.</p> <p>6. Clinical record # 9, start of care 9/16/13, included a plan of care the certification period 9/16/13 through 11/15/13 with orders for SN visits 1 visit weekly for 8 weeks for education for the diagnosis and management of diabetes and hypertension. The record failed to</p>			

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	<p>evidence any care was provided the first week of the certification period dated 9/16/13 to 9/22/13. The first visit made was on 9/27/13.</p> <p>7. On 11/4/13 at 3:40 PM, employee B indicated the first visit to the home was the skilled nurse to complete the comprehensive assessment and then care was not provided until the agency received the plan of care with the signature of the physician. She indicated no care was rendered during the assessment visits.</p>			

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N000524	<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> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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>Based on clinical record and interview, the agency failed to ensure the plan of care included the instructions for the monitoring of medications that require therapeutic monitoring via blood levels or who was monitoring the patient's blood levels in 1 of 5 records reviewed of patients that received skilled nurse services and preset of their medications with the potential to affect all patients that take medications that require therapeutic blood level monitoring. (# 6)</p>	N000524	Clinicians will be educated that all medications will be included on the plan of care and medication profile to include frequency, dosage, and administration route. Clinicians educated on high risk drugs that require regular monitoring and the process for documenting who is responsible for monitoring. 100% of the charts will be checked by the DON for 30 days and 10% thereafter for evidence that all medications including route, dosage and frequency are	11/20/2013			

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 6, start of care 9/12/13 included a plan of care dated 9/12/13 through 11/1/13 with orders for the skilled nurse to preset the patient's medications weekly for 8 weeks. The plan of care did not include the patient's medications and stated, "See attached." The medication profile included the medication Digoxin 125 microgram to be taken once daily. [Digoxin requires monitoring of blood levels for therapeutic dosing.] The record failed to evidence who was monitoring the patient's Digoxin levels. 2. On 11/4/13 at 1:27 PM, during record review, employee B indicated she was not aware of whom was monitoring the patients Digoxin levels if anyone. 		included on the medication profile and plan of care and that high risk drugs are being monitored properly. The DON is responsible for compliance.				

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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, clinical record, and policy 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 at 410 IAC 17-14-1(h) in 1 (file E) of 1 home health aide file reviewed, the only aide employed by the agency, creating the potential to affect the one patient (patient 2) who received home health aide services.</p> <p>The findings include:</p> <p>1. Personnel file E evidenced the individual had been hired on 8/12/13 to provide home health aide services on behalf of the agency. The file evidenced a competency evaluation had been administered on 8/12/13. The competency evaluation failed to evidence the aide had been evaluated for the competent performance of vital signs as</p>	N000596	The Director of Nursing will ensure that each home health aide completes a competency evaluation before providing patient care. The aide must pass a written competency exam and a RN will complete a skills checklist per standard with direct observation of vital signs, appropriate and safe techniques in personal hygiene and grooming to include; bed bath, sponge, tub or shower bath, shampoo, nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, and normal range of motion and positioning. 100% of employee files will be audited to ensure the deficiency is corrected and complacency is maintained.	11/20/2013			

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	<p>required by 410 IAC 17-14-1 (h)(3), appropriate and safe techniques in personal hygiene and grooming that include a bed bath, nail and skin care, and toileting and elimination as required by 410 IAC 17-14-1 (h)(9)(A)(D) and (F), safe transfer techniques and ambulation as required by 410 IAC 17-14-(h)(10), and normal range of motion and positioning as required by 410 IAC 17-14-(h)(11).</p> <p>Clinical record # 2, start of care 8/23/13, included documentation employee E provided services on August 28 and 30; September 3, 6, 10, 13, 17, 20, 24, and 27; and October 1, 4, 8, and 11, 2013.</p> <p>2. The supervising nurse, employee B, indicated, on 10/31/13 at 11:36 AM during the entrance conference, that employee E was only evaluated for the tasks required to care for patient # 2. She indicated the employee was evaluated as she performed and provided a shower, shampoo, and assisted patient # 2 to ambulate, and no other tasks were evaluated.</p> <p>3. The policy titled "Quality Management - Nursing Aide / HHA" stated, "All aide services are provided in accordance with the recognized state regulations. ... Aide Training. The aide must pass a HHA</p>						

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	[home health aide] competency exam and a registered nurse will complete a competency assessment skills checklist with direct observation of each skill for each aide before assignment begins."			