

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157582	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2013
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NAME OF PROVIDER OR SUPPLIER INNOVATIVE SENIOR CARE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5354 W 62ND ST INDIANAPOLIS, IN 46268
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G0000	<p>This visit was a Home Health federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: January 14-17, 2013 Partial Extended Survey Dates: January 17, 2013</p> <p>Facility Number: 011129</p> <p>Provider Number: 157582</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor - Team Leader David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 448 Home Health Aide Only: 0 Personal Care Only: 0 Total: 448</p> <p>Sample: RR w/HV: 5 RR w/o HV: 7 Total: 12</p> <p>Quality Review: Joyce Elder, MSN, BSN,</p>	G0000		
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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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	RN January 24, 2013			

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G0123	<p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable.</p> <p>Based on document review and interview, the home health agency failed to ensure the organizational chart clearly identified administrative control for 1 of 1 agency reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Indiana State Department of Health Documentation titled "Renewal Application for License to Operate a Home Health Agency" dated 6/26/12, lists "Innovative Senior Care Home Health of Indianapolis LLC" as the name of applicant entity / licensee doing business as Innovative Senior Care Home Health. 2. Review of the agency organizational chart titled "Innovative Senior Care Home Health" indicates "ARC Therapy Services LLC d/b/a [doing business as] Innovative Senior Care Home Health." 3. On 1/17/13 at 5:10 PM, employee E, 			G0123	<p>On 1/18/13 the Senior Director for Regulatory Practices for Innovative Senior Care spoke with the Indiana State Program Coordinator and clarified ownership information for Innovative Senior Care. The Senior Director submitted the correct organizational chart to the state. A copy of the organizational chart can also be found in the Administrative manual at the agency.</p>		01/18/2013

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	Quality Assurance RN, indicated the organizational chart must be wrong. Employee E indicated there has been no change in ownership.			

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G0143	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure coordination of care occurred among all personnel furnishing services and the physician for 1 of 12 clinical records reviewed with the potential to affect all patients of the agency. (#5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Medical Supervision" policy number C-645, revised 10/1/07 states, "Physician will be contacted when any of the following occurs: condition changes ... Any change in patient condition." The policy titled "Coordination of Patient Services" policy number C-360, revised 10/1/07 states, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, 	G0143	<p>At an in-service conducted on 1/21/13 by the Administrator and Director of Professional Services (DPS), all nursing staff were re-educated on the policy and procedure for notifying a physician when there is a change in the patient's condition. This education emphasized the expectation that LPN staff will report changes in patient condition to the supervising RN as well as the Physician. This care coordination will be reflected in the clinical record by a coordination note. A follow up in-service will be held the week of 2/4/12. This in-service will specifically review policy C-645 (Medical Supervision), C-360 (Coordination of Patient Services) and nursing job descriptions.</p> <p>The Director of Professional Services will conduct a random audit of 5 client records per week beginning the week of 2/4/13 for evidence that changes in patient condition are being reported to the supervising RN as well as the Physician and documented in the clinical record. This process will continue until 100% compliance has been achieved and maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored</p>	02/08/2013	

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	<p>current care plans; and written and verbal interaction."</p> <p>3. The undated job description titled "Nurse LPN/LVN - HH" states, "Performs ongoing assessment during each visit and documents data in patient medical records. Communications significant findings, problems, or changes in the patient's condition to the supervising RN and/or Director of Professional Services and the physician and documents all findings, communications and appropriate interventions."</p> <p>4. Clinical record #5, start of care 12/31/12, contained a home health certification and plan of care dated 12/31/12 - 2/28/13 which states "Changes in patient co-morbid status will be promptly identified and reported to the physician ... Skilled nurse to assess/evaluate ... other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications." The nursing clinical note dated 1/12/13 completed by employee H, Licensed Practical Nurse (LPN), evidenced under the Respiratory section that the patient had "abnormal breath sounds ... diminished / distant left upper lobe." The record evidenced the LPN failed to</p>		<p>through the ongoing Quality Improvement process. The Director of Professional services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	

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	<p>notify the supervising RN or attending physician of the change in patient condition.</p> <p>5. During an interview on 1/16/13 at 3:00 PM, employee II, Director of Nursing, indicated there was no need for the LPN to report the change in condition to the physician or RN. Employee II indicated the LPN was scheduled to see the patient today and would probably just reassess them at that time.</p> <p>6. During an interview on 1/16/13 at 4:30 PM, employee E, Quality Assurance RN, indicated the physician and RN case manager should have been contacted to report the change in condition.</p>			

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G0158	<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 policy review, clinical record review, and interview, the home health agency failed to ensure wound care was provided as required by agency policy and physical therapy visits were made in accordance with the plan of care in 6 of 12 records reviewed with the potential to affect all the agency's patients who received skilled nursing and physical therapy services. (#1, 4, 7, 8, 9, and 10).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Application of Dry Dressing" policy number G-100, dated August 2002 states, "Documentation Guidelines - Document in the clinical record: ... dressing procedure and time of dressing change; wound measurement weekly." 2. Facility policy titled "Clinical Documentation" policy number C-680, revised 10/1/07 states, "Services not provided and the reason for the missed visits will be documented and reported 			G0158	<p>At an in-service conducted on 1/21/13 by the Administrator and DPS, all nursing staff were re-educated on the wound care policy. This education emphasized the expectation that wounds will be measured weekly. A follow up in-service will be held by DPS the week of 2/4/12. This in-service will specifically review policy G-100, C-680(clinical documentation) and C-580(Plan of Care). The Administrator will conduct an in-service for the therapy staff the week of 2/4/12. During this in-service the therapy staff will be reeducated on policy C-680 (Clinical Documentation), C-580 (Plan of care). Education will include instruction on providing care and treatments as it is ordered by the physician with respect to frequencies and duration of visits. Staff will be re-instructed to obtain verbal orders for any changes to existing orders. The Director of Professional Services will conduct a random audit of 5 client records per week beginning the week of 2/4/13 for evidence of weekly wound measurements. This process will continue until 100% compliance has been achieved and</p>		02/08/2013

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	<p>to the physician."</p> <p>3. Clinical record #1, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/21/12, employee KK, Registered Nurse (RN) Case Manager, failed to document any wound measurements at the start of care.</p> <p>B. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/26/12, and 12/28/12 failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/24/12, employee KK, RN Case Manager, failed to document any wound measurements.</p> <p>2.) On 12/26/12, employee II, Director of Nursing (DON), failed to document any wound measurements.</p> <p>3.) On 12/28/12, employee EE,</p>		<p>maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process.</p> <p>The Director of Professional services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p> <p>The Administrator will conduct a random audit of 5 client records per week beginning the week of 2/11/13 for evidence that therapy staff is following the frequency as indicated on the physician approved plan of care. This process will continue until 100% compliance has been achieved and maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process.</p> <p>The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	

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	<p>Licensed Practical Nurse (LPN), failed to document any wound measurements.</p> <p>C. On 1/16/13 at 5:07 PM, employee E, Quality Assurance RN, indicated wounds should be measured weekly.</p> <p>D. On 1/17/13 at 10:00 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented at the start of care on 12/21/12 or the week of 12/23/12.</p> <p>4. Clinical record #4, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower back/hip three times per week. The week of 12/16/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/17/12, 12/19/12, and 12/20/12 failed to evidence any wound measurements were made that week.</p> <p>A. On 12/17/12, employee KK, RN Case Manager, failed to document any wound measurements.</p> <p>B. On 12/19/12, employee H, LPN, failed to document any wound measurements.</p>			

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	<p>C. On 12/20/12, employee LL, RN Case Manager, failed to document any wound measurements.</p> <p>D. On 1/17/12 at 10:25 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented the week of 12/16/12.</p> <p>5. Clinical record #7, start of care 12/19/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/19/12 to 2/16/13 with orders for Physical Therapy 1 time per week for 1 week, 2 times per week for 3 weeks, and 1 time per week for 1 week. Review of the Physical Therapy Visit Notes evidenced only one of two physical therapy visits were made the week of 12/23/12. No missed visit documentation or doctor notification was found in the record.</p> <p>On 1/17/13 at 5:00 PM, employee II, DON, indicated no missed visit note documentation could be found.</p> <p>6. Clinical record #8, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to "perform/teach decubitus care to rt</p>			

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	<p>[right] buttock and lt [left] buttock above rectal area with NS [normal saline] or wound cleanser. Pat dry with gauze. Cover with hydrocolloid dressing, cover with transparent dressings ... change 3 x [times a] week and PRN [as needed] for soiled or dislodged dressing. Measure weekly and PRN." Review of the Nursing Notes evidenced the following:</p> <p>A. The week of 12/23/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, and 12/27/12 failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/24/12, employee K, RN Case Manager, failed to document any wound measurements or dressing change.</p> <p>2.) On 12/27/12, employee K, RN Case Manager, failed to document any wound measurements.</p> <p>B. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13, and 1/10/13 failed to evidence any wound measurements were made that week</p> <p>1.) On 1/7/13, employee K, RN Case Manager, failed to document any</p>			

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	<p>wound measurements.</p> <p>2.) On 1/10/113, employee H, LPN, failed to document any wound measurements.</p> <p>7. Clinical record #9, start of care 12/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/5/12 to 2/2/13 with orders for skilled nursing to perform decubitus care to buttocks. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/5/12, employee KK, RN Case Manager, failed to document any wound measurements at start of care.</p> <p>B. The week of 12/9/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/10/12 and 12/13/12 failed to evidence any wound measurements were made that week.</p> <p>On 12/10/12 and 12/13/12, employee EE, LPN, failed to document any wound measurements.</p> <p>8. Clinical record #10, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to</p>			

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	<p>2/4/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/7/12, employee KK, RN Case Manager, failed to document any wound measurements at the start of care.</p> <p>B. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/27/12, and 12/28/12, completed by employee KK, RN Case Manager, failed to evidence any wound measurements were made that week.</p> <p>C. The week of 12/30/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/31/12, 1/2/13, and 1/4/13, failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/31/12, employee EE, LPN, failed to document any wound measurements.</p> <p>2.) On 1/2/13, employee II, DON, failed to document any wound measurements.</p>			

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	<p>3.) On 1/4/13, employee II, DON, failed to document any wound measurements.</p> <p>D. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13 and 1/11/13, completed by employee EE, LPN, failed to evidence any wound measurements were made that week.</p>			

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G0170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure wound care was provided as required by agency policy and in accordance with the plan of care in 5 of 12 records reviewed with the potential to affect all the agency's patients who received skilled nursing and physical therapy services. (#1, 4, 8, 9, and 10).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Application of Dry Dressing" policy number G-100, dated August 2002 states, "Documentation Guidelines - Document in the clinical record: ... dressing procedure and time of dressing change; wound measurement weekly." 2. Clinical record #1, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the 			G0170	<p>At an in-service conducted on 1/21/13 by the Administrator and DPS, all nursing staff were re-educated on the wound care policy. This education emphasized the expectation that wounds will be measured weekly.</p> <p>The Director of Professional Services will conduct a random audit of 5 client records per week beginning the week of 2/4/13 for evidence of weekly wound measurements. This process will continue until 100% compliance has been achieved and maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process.</p> <p>The Director of Professional services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>		02/08/2013

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	<p>following:</p> <p>A. On 12/21/12, employee KK, Registered Nurse (RN) Case Manager, failed to document any wound measurements at the start of care.</p> <p>B. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/26/12, and 12/28/12 failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/24/12, employee KK, RN Case Manager, failed to document any wound measurements.</p> <p>2.) On 12/26/12, employee II, Director of Nursing (DON), failed to document any wound measurements.</p> <p>3.) On 12/28/12, employee EE, Licensed Practical Nurse (LPN), failed to document any wound measurements.</p> <p>C. On 1/16/13 at 5:07 PM, employee E, Quality Assurance RN, indicated wounds should be measured weekly.</p> <p>D. On 1/17/13 at 10:00 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented</p>			

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	<p>at the start of care on 12/21/12 or the week of 12/23/12.</p> <p>3. Clinical record #4, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower back/hip three times per week. The week of 12/16/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/17/12, 12/19/12, and 12/20/12 failed to evidence any wound measurements were made that week.</p> <p>A. On 12/17/12, employee KK, RN Case Manager, failed to document any wound measurements.</p> <p>B. On 12/19/12, employee H, LPN, failed to document any wound measurements.</p> <p>C. On 12/20/12, employee LL, RN Case Manager, failed to document any wound measurements.</p> <p>D. On 1/17/12 at 10:25 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented the week of 12/16/12.</p> <p>4. Clinical record #8, start of care</p>			

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	<p>12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to "perform/teach decubitus care to rt [right] buttock and lt [left] buttock above rectal area with NS [normal saline] or wound cleanser. Pat dry with gauze. Cover with hydrocolloid dressing, cover with transparent dressings ... change 3 x [times a] week and PRN [as needed] for soiled or dislodged dressing. Measure weekly and PRN." Review of the Nursing Notes evidenced the following:</p> <p>A. The week of 12/23/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, and 12/27/12 failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/24/12, employee K, RN Case Manager, failed to document any wound measurements or dressing change.</p> <p>2.) On 12/27/12, employee K, RN Case Manager, failed to document any wound measurements.</p> <p>B. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13, and</p>			

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	<p>1/10/13 failed to evidence any wound measurements were made that week</p> <p>1.) On 1/7/13, employee K, RN Case Manager, failed to document any wound measurements.</p> <p>2.) On 1/10/113, employee H, LPN, failed to document any wound measurements.</p> <p>5. Clinical record #9, start of care 12/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/5/12 to 2/2/13 with orders for skilled nursing to perform decubitus care to buttocks. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/5/12, employee KK, RN Case Manager, failed to document any wound measurements at start of care.</p> <p>B. The week of 12/9/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/10/12 and 12/13/12 failed to evidence any wound measurements were made that week.</p> <p>On 12/10/12 and 12/13/12, employee EE, LPN, failed to document any wound measurements.</p>						

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	<p>6. Clinical record #10, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/7/12, employee KK, RN Case Manager, failed to document any wound measurements at the start of care.</p> <p>B. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/27/12, and 12/28/12, completed by employee KK, RN Case Manager, failed to evidence any wound measurements were made that week.</p> <p>C. The week of 12/30/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/31/12, 1/2/13, and 1/4/13, failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/31/12, employee EE, LPN, failed to document any wound measurements.</p>			
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	<p>2.) On 1/2/13, employee II, DON, failed to document any wound measurements.</p> <p>3.) On 1/4/13, employee II, DON, failed to document any wound measurements.</p> <p>D. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13 and 1/11/13, completed by employee EE, LPN, failed to evidence any wound measurements were made that week.</p>						

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G0179	<p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes services in accordance with agency policy. Based on policy review, job description review, record review, and interview, the home health agency failed to ensure the licensed practical nurse (LPN) furnished services in accordance with agency policy in 5 of 12 records reviewed with the potential to affect all patients of the agency who receive services by a licensed practical nurse. (#1, 4, 5, 9, and 10)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Application of Dry Dressing" policy number G-100, dated August 2002 states, "Documentation Guidelines - Document in the clinical record: ... dressing procedure and time of dressing change; wound measurement weekly." 2. The policy titled "Medical Supervision" policy number C-645, revised 10/1/07 states, "Physician will be contacted when any of the following occurs: condition changes, expected response to treatment or medication changes ... Any change in patient condition." 	G0179	At an in-service conducted on 1/21/13 by the Administrator and Director of Professional Services (DPS), all nursing staff were re-educated on the policy and procedure for notifying a physician when there is a change in the patient's condition. This education emphasized the expectation that LPN staff will report changes in patient condition to the supervising RN as well as the Physician. This care coordination will be reflected in the clinical record by a coordination note. Additionally all nursing staff were re-educated on the wound care policy. This education emphasized the expectation that wounds will be measured weekly. A follow up in-service will be held the week of 2/4/12. This in-service will specifically review policy C-645 (Medical Supervision), C-360 (Coordination of Patient Services), G-100, C-680 (clinical documentation) and C-580 (Plan of Care) and nursing job descriptions specifically job responsibilities. The Director of Professional Services will conduct a random audit of 5 client records per week beginning the week of 2/4/13 for evidence of weekly wound measurements and that changes in patient condition are	02/08/2013			

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	<p>3. The undated job description titled "Nurse LPN/LVN - HH" states, "Verifies Plan of Care prior to each visit and provides care according to the physician's orders ... Performs ongoing assessment during each visit and documents data in patient medical records. Communications significant findings, problems, or changes in the patient's condition to the supervising RN [registered nurse] and/or Director of Professional Services and the physician and documents all findings, communications and appropriate interventions."</p> <p>4. The policy titled "Coordination of Patient Services" policy number C-360, revised 10/1/07 states, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current care plans; and written and verbal interaction."</p> <p>5. Clinical record #1, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to</p>		<p>being reported to the supervising RN as well as the physician and documented in the clinical record. This process will continue until 100% compliance has been achieved and maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process. The Director of Professional services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	

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	<p>2/18/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week.</p> <p>A. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/26/12, and 12/28/12 failed to evidence any wound measurements were made that week. The LPN, employee EE, made the 12/28/visit.</p> <p>B. . On 1/16/13 at 5:07 PM, employee E, Quality Assurance RN, indicated wounds should be measured weekly.</p> <p>C. On 1/17/13 at 10:00 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented at the start of care on 12/21/12 or the week of 12/23/12.</p> <p>6. Clinical record #4, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower back/hip three times per week. The week of 12/16/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/17/12, 12/19/12, and 12/20/12 failed to evidence any wound</p>			

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	<p>measurements were made that week.</p> <p>The LPN, employee H, made the 12/19/12 visit.</p> <p>On 1/17/12 at 10:25 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented the week of 12/16/12.</p> <p>7. Clinical record #5, start of care 12/31/12, contained a home health certification and plan of care dated 12/31/12 - 2/28/13 which states "Changes in patient co-morbid status will be promptly identified and reported to the physician ... Skilled nurse to assess/evaluate ... other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 1/12/13, employee H, LPN, documented under the Respiratory section that the patient had "abnormal breath sounds ... diminished/distant left upper lobe." Review of the clinical record evidenced the LPN failed to notify the supervising RN or attending physician of the change in patient condition.</p> <p>B. During an interview on 1/16/13 at</p>			

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	<p>3:00 PM, employee II, Director of Nursing, indicated there was no need for the LPN to report the change in condition to the physician or RN. Employee II indicated the LPN was scheduled to see the patient today and would probably just reassess them at that time.</p> <p>C. During an interview on 1/16/13 at 4:30 PM, employee E, Quality Assurance RN, indicated the physician and RN case manager should have been contacted to report the change in condition.</p> <p>8. Clinical record #8, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to "perform/teach decubitus care to rt [right] buttock and lt [left] buttock above rectal area with NS [normal saline] or wound cleanser. Pat dry with gauze. Cover with hydrocolloid dressing, cover with transparent dressings ... change 3 x [times a] week and PRN [as needed] for soiled or dislodged dressing. Measure weekly and PRN." Review of the Nursing Notes evidenced the following:</p> <p>The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing</p>			

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	<p>visit notes from 1/7/13, and 1/10/13 failed to evidence any wound measurements were made that week. Employee H, LPN, made the visit on 1/10/13.</p> <p>5. Clinical record #9, start of care 12/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/5/12 to 2/2/13 with orders for skilled nursing to perform decubitus care to buttocks. Review of the Nursing Visit Notes evidenced the following:</p> <p>The week of 12/9/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/10/12 and 12/13/12 failed to evidence any wound measurements were made that week. Employee EE, LPN, made these visits.</p> <p>9. Clinical record #10, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. The week of 12/30/12, three skilled</p>			

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	<p>nursing visits were made. Review of the Nursing visit notes from 12/31/12, 1/2/13, and 1/4/13, failed to evidence any wound measurements were made that week. Employee EE, LPN, made the visit on 12/31/12.</p> <p>B. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13 and 1/11/13, completed by employee EE, LPN, failed to evidence any wound measurements were made that week.</p>			

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G0337	<p>484.55(c) DRUG REGIMEN REVIEW 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 policy review, clinical record review, and interview, the agency failed to ensure the medication profile was updated and accurate when there were medication changes in 1 of 12 clinical records reviewed with the potential to affect all patients at this agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Medical Supervision" policy number C-645, revised 10/1/07 states, "Physician will be contacted when any of the following occurs: ... expected response to treatment or medication changes." Clinical record #11, start of care 5/6/12, included a Home Health Certification and Plan of Care for the certification period from 5/6/12 to 7/4/12. Review of the clinical record evidenced the following: 	G0337	<p>During the in-service to be held week of 2/4/13 for all nursing staff the Director of Professional Services will reeducate nursing staff on Policy C-700 (Medication Profile) with emphasis on the need to update the medication profile when changes occur.</p> <p>The Director of Professional Services will conduct a random audit of 5 client records per week beginning the week of 2/11/13 for evidence of the medication profile being updated when changes occur. This process will continue until 100% compliance has been achieved and maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process.</p> <p>The Director of Professional services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	02/08/2013	

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	<p>A. A Nursing Visit Record, signed and dated on 6/1/12 by employee NN, Licensed Practical Nurse, evidenced a order change was made for "Lisinopril 40 mg [milligrams] BID [two times per day]."</p> <p>B. Review of the Medication Profile failed to evidence the order change for Lisinopril 40 mg BID was documented. The last review date was completed on 5/6/12.</p> <p>C. On 1/15/13 at 3:00 PM, employee E, Quality Assurance Registered Nurse, indicated the medication profile should have been updated when the dose change occurred.</p>			

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N0000	<p>This visit was a Home Health state licensure survey.</p> <p>Survey Dates: January 14-17, 2013</p> <p>Facility Number: 011129</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor - Team Leader David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 448 Home Health Aide Only: 0 Personal Care Only: 0 Total: 448</p> <p>Sample: RR w/HV: 5 RR w/o HV: 7 Total: 12</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 24, 2013</p>	N0000			

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N0440	<p>410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable.</p> <p>Based on document review and interview, the home health agency failed to ensure the organizational chart clearly identified administrative control for 1 of 1 agency reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Indiana State Department of Health Documentation titled "Renewal Application for License to Operate a Home Health Agency" dated 6/26/12, lists "Innovative Senior Care Home Health of Indianapolis LLC" as the name of applicant entity / licensee doing business as Innovative Senior Care Home Health. 2. Review of the agency organizational chart titled "Innovative Senior Care Home Health" indicates "ARC Therapy Services LLC d/b/a [doing business as] Innovative Senior Care Home Health." 3. On 1/17/13 at 5:10 PM, employee E, 	N0440	<p>On 1/18/13 the Senior Director for Regulatory Practices for Innovative Senior Care spoke with the Indiana State Program Coordinator and clarified ownership information for Innovative Senior Care. The Senior Director submitted the correct organizational chart to the state. A copy of the organizational chart can also be found in the Administrative manual at the agency.</p>	01/18/2013	

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	Quality Assurance RN, indicated the organizational chart must be wrong. Employee E indicated there has been no change in ownership.				

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N0484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure coordination of care occurred among all personnel furnishing services and the physician for 1 of 12 clinical records reviewed with the potential to affect all patients of the agency. (#5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Medical Supervision" policy number C-645, revised 10/1/07 states, "Physician will be contacted when any of the following occurs: condition changes ... Any change in patient condition." The policy titled "Coordination of Patient Services" policy number C-360, revised 10/1/07 states, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the 	N0484	<p>At an in-service conducted on 1/21/13 by the Administrator and Director of Professional Services (DPS), all nursing staff were re-educated on the policy and procedure for notifying a physician when there is a change in the patient's condition. This education emphasized the expectation that LPN staff will report changes in patient condition to the supervising RN as well as the Physician. This care coordination will be reflected in the clinical record by a coordination note. A follow up in-service will be held the week of 2/4/12. This in-service will specifically review policy C-645 (Medical Supervision), C-360 (Coordination of Patient Services) and nursing job descriptions.</p> <p>The Director of Professional Services will conduct a random audit of 5 client records per week beginning the week of 2/4/13 for evidence that changes in patient condition are being reported to the supervising RN as well as the Physician and documented in the clinical record. This process will continue until 100%</p>	02/08/2013

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	<p>objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current care plans; and written and verbal interaction."</p> <p>3. The undated job description titled "Nurse LPN/LVN - HH" states, "Performs ongoing assessment during each visit and documents data in patient medical records. Communications significant findings, problems, or changes in the patient's condition to the supervising RN and/or Director of Professional Services and the physician and documents all findings, communications and appropriate interventions."</p> <p>4. Clinical record #5, start of care 12/31/12, contained a home health certification and plan of care dated 12/31/12 - 2/28/13 which states "Changes in patient co-morbid status will be promptly identified and reported to the physician ... Skilled nurse to assess/evaluate ... other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications." The nursing clinical note dated 1/12/13 completed by employee H, Licensed Practical Nurse (LPN), evidenced under the Respiratory section that the patient</p>		<p>compliance has been achieved and maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process. The Director of Professional services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>				

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	<p>had "abnormal breath sounds ... diminished / distant left upper lobe." The record evidenced the LPN failed to notify the supervising RN or attending physician of the change in patient condition.</p> <p>5. During an interview on 1/16/13 at 3:00 PM, employee II, Director of Nursing, indicated there was no need for the LPN to report the change in condition to the physician or RN. Employee II indicated the LPN was scheduled to see the patient today and would probably just reassess them at that time.</p> <p>6. During an interview on 1/16/13 at 4:30 PM, employee E, Quality Assurance RN, indicated the physician and RN case manager should have been contacted to report the change in condition.</p>			

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N0522	<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:</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure wound care was provided as required by agency policy and physical therapy visits were made in accordance with the plan of care in 6 of 12 records reviewed with the potential to affect all the agency's patients who received skilled nursing and physical therapy services. (#1, 4, 7, 8, 9, and 10).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Application of Dry Dressing" policy number G-100, dated August 2002 states, "Documentation Guidelines - Document in the clinical record: ... dressing procedure and time of dressing change; wound measurement weekly." 2. Facility policy titled "Clinical Documentation" policy number C-680, revised 10/1/07 states, "Services not provided and the reason for the missed visits will be documented and reported 	N0522	<p>At an in-service conducted on 1/21/13 by the Administrator and DPS, all nursing staff were re-educated on the wound care policy. This education emphasized the expectation that wounds will be measured weekly. A follow up in-service will be held by DPS the week of 2/4/12. This in-service will specifically review policy G-100, C-680(clinical documentation) and C-580(Plan of Care). The Administrator will conduct an in-service for the therapy staff the week of 2/4/12. During this in-service the therapy staff will be reeducated on policy C-680 (Clinical Documentation), C-580 (Plan of care). Education will include instruction on providing care and treatments as it is ordered by the physician with respect to frequencies and duration of visits. Staff will be re-instructed to obtain verbal orders for any changes to existing orders. The Director of Professional Services will conduct a random audit of 5 client records per week beginning the week of 2/4/13 for evidence of weekly wound measurements. This process will continue until 100% compliance has been achieved and</p>	02/08/2013			

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	<p>to the physician."</p> <p>3. Clinical record #1, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/21/12, employee KK, Registered Nurse (RN) Case Manager, failed to document any wound measurements at the start of care.</p> <p>B. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/26/12, and 12/28/12 failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/24/12, employee KK, RN Case Manager, failed to document any wound measurements.</p> <p>2.) On 12/26/12, employee II, Director of Nursing (DON), failed to document any wound measurements.</p> <p>3.) On 12/28/12, employee EE,</p>		<p>maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process.</p> <p>The Director of Professional services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p> <p>The Administrator will conduct a random audit of 5 client records per week beginning the week of 2/11/13 for evidence that therapy staff is following the frequency as indicated on the physician approved plan of care. This process will continue until 100% compliance has been achieved and maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process.</p> <p>The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>		

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	<p>Licensed Practical Nurse (LPN), failed to document any wound measurements.</p> <p>C. On 1/16/13 at 5:07 PM, employee E, Quality Assurance RN, indicated wounds should be measured weekly.</p> <p>D. On 1/17/13 at 10:00 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented at the start of care on 12/21/12 or the week of 12/23/12.</p> <p>4. Clinical record #4, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower back/hip three times per week. The week of 12/16/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/17/12, 12/19/12, and 12/20/12 failed to evidence any wound measurements were made that week.</p> <p>A. On 12/17/12, employee KK, RN Case Manager, failed to document any wound measurements.</p> <p>B. On 12/19/12, employee H, LPN, failed to document any wound measurements.</p>			

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	<p>C. On 12/20/12, employee LL, RN Case Manager, failed to document any wound measurements.</p> <p>D. On 1/17/12 at 10:25 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented the week of 12/16/12.</p> <p>5. Clinical record #7, start of care 12/19/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/19/12 to 2/16/13 with orders for Physical Therapy 1 time per week for 1 week, 2 times per week for 3 weeks, and 1 time per week for 1 week. Review of the Physical Therapy Visit Notes evidenced only one of two physical therapy visits were made the week of 12/23/12. No missed visit documentation or doctor notification was found in the record.</p> <p>On 1/17/13 at 5:00 PM, employee II, DON, indicated no missed visit note documentation could be found.</p> <p>6. Clinical record #8, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to "perform/teach decubitus care to rt</p>			

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	<p>[right] buttock and [left] buttock above rectal area with NS [normal saline] or wound cleanser. Pat dry with gauze. Cover with hydrocolloid dressing, cover with transparent dressings ... change 3 x [times a] week and PRN [as needed] for soiled or dislodged dressing. Measure weekly and PRN." Review of the Nursing Notes evidenced the following:</p> <p>A. The week of 12/23/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, and 12/27/12 failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/24/12, employee K, RN Case Manager, failed to document any wound measurements or dressing change.</p> <p>2.) On 12/27/12, employee K, RN Case Manager, failed to document any wound measurements.</p> <p>B. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13, and 1/10/13 failed to evidence any wound measurements were made that week</p> <p>1.) On 1/7/13, employee K, RN Case Manager, failed to document any</p>			

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	<p>wound measurements.</p> <p>2.) On 1/10/113, employee H, LPN, failed to document any wound measurements.</p> <p>7. Clinical record #9, start of care 12/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/5/12 to 2/2/13 with orders for skilled nursing to perform decubitus care to buttocks. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/5/12, employee KK, RN Case Manager, failed to document any wound measurements at start of care.</p> <p>B. The week of 12/9/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/10/12 and 12/13/12 failed to evidence any wound measurements were made that week.</p> <p>On 12/10/12 and 12/13/12, employee EE, LPN, failed to document any wound measurements.</p> <p>8. Clinical record #10, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to</p>			

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	<p>2/4/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/7/12, employee KK, RN Case Manager, failed to document any wound measurements at the start of care.</p> <p>B. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/27/12, and 12/28/12, completed by employee KK, RN Case Manager, failed to evidence any wound measurements were made that week.</p> <p>C. The week of 12/30/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/31/12, 1/2/13, and 1/4/13, failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/31/12, employee EE, LPN, failed to document any wound measurements.</p> <p>2.) On 1/2/13, employee II, DON, failed to document any wound measurements.</p>			

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	<p>3.) On 1/4/13, employee II, DON, failed to document any wound measurements.</p> <p>D. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13 and 1/11/13, completed by employee EE, LPN, failed to evidence any wound measurements were made that week.</p>			

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N0537	<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:</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure wound care was provided as required by agency policy and in accordance with the plan of care in 5 of 12 records reviewed with the potential to affect all the agency's patients who received skilled nursing and physical therapy services. (#1, 4, 8, 9, and 10).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Application of Dry Dressing" policy number G-100, dated August 2002 states, "Documentation Guidelines - Document in the clinical record: ... dressing procedure and time of dressing change; wound measurement weekly." 2. Clinical record #1, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to 	N0537	<p>At an in-service conducted on 1/21/13 by the Administrator and DPS, all nursing staff were re-educated on the wound care policy. This education emphasized the expectation that wounds will be measured weekly.</p> <p>The Director of Professional Services will conduct a random audit of 5 client records per week beginning the week of 2/4/13 for evidence of weekly wound measurements. This process will continue until 100% compliance has been achieved and maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process.</p> <p>The Director of Professional services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	02/08/2013			

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	<p>perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/21/12, employee KK, Registered Nurse (RN) Case Manager, failed to document any wound measurements at the start of care.</p> <p>B. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/26/12, and 12/28/12 failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/24/12, employee KK, RN Case Manager, failed to document any wound measurements.</p> <p>2.) On 12/26/12, employee II, Director of Nursing (DON), failed to document any wound measurements.</p> <p>3.) On 12/28/12, employee EE, Licensed Practical Nurse (LPN), failed to document any wound measurements.</p> <p>C. On 1/16/13 at 5:07 PM, employee E, Quality Assurance RN, indicated wounds should be measured weekly.</p>			

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	<p>D. On 1/17/13 at 10:00 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented at the start of care on 12/21/12 or the week of 12/23/12.</p> <p>3. Clinical record #4, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower back/hip three times per week. The week of 12/16/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/17/12, 12/19/12, and 12/20/12 failed to evidence any wound measurements were made that week.</p> <p>A. On 12/17/12, employee KK, RN Case Manager, failed to document any wound measurements.</p> <p>B. On 12/19/12, employee H, LPN, failed to document any wound measurements.</p> <p>C. On 12/20/12, employee LL, RN Case Manager, failed to document any wound measurements.</p> <p>D. On 1/17/12 at 10:25 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented</p>			

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	<p>the week of 12/16/12.</p> <p>4. Clinical record #8, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to "perform/teach decubitus care to rt [right] buttock and lt [left] buttock above rectal area with NS [normal saline] or wound cleanser. Pat dry with gauze. Cover with hydrocolloid dressing, cover with transparent dressings ... change 3 x [times a] week and PRN [as needed] for soiled or dislodged dressing. Measure weekly and PRN." Review of the Nursing Notes evidenced the following:</p> <p>A. The week of 12/23/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, and 12/27/12 failed to evidence any wound measurements were made that week.</p> <p>1.) On 12/24/12, employee K, RN Case Manager, failed to document any wound measurements or dressing change.</p> <p>2.) On 12/27/12, employee K, RN Case Manager, failed to document any wound measurements.</p>						

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	<p>B. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13, and 1/10/13 failed to evidence any wound measurements were made that week</p> <p>1.) On 1/7/13, employee K, RN Case Manager, failed to document any wound measurements.</p> <p>2.) On 1/10/113, employee H, LPN, failed to document any wound measurements.</p> <p>5. Clinical record #9, start of care 12/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/5/12 to 2/2/13 with orders for skilled nursing to perform decubitus care to buttocks. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/5/12, employee KK, RN Case Manager, failed to document any wound measurements at start of care.</p> <p>B. The week of 12/9/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/10/12 and 12/13/12 failed to evidence any wound measurements were made that week.</p>			

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	<p>On 12/10/12 and 12/13/12, employee EE, LPN, failed to document any wound measurements.</p> <p>6. Clinical record #10, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 12/7/12, employee KK, RN Case Manager, failed to document any wound measurements at the start of care.</p> <p>B. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/27/12, and 12/28/12, completed by employee KK, RN Case Manager, failed to evidence any wound measurements were made that week.</p> <p>C. The week of 12/30/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/31/12, 1/2/13, and 1/4/13, failed to evidence any wound measurements were made that week.</p>			

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	<p>1.) On 12/31/12, employee EE, LPN, failed to document any wound measurements.</p> <p>2.) On 1/2/13, employee II, DON, failed to document any wound measurements.</p> <p>3.) On 1/4/13, employee II, DON, failed to document any wound measurements.</p> <p>D. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13 and 1/11/13, completed by employee EE, LPN, failed to evidence any wound measurements were made that week.</p>				

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N0553	<p>410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies.</p> <p>Based on policy review, job description review, record review, and interview, the home health agency failed to ensure the licensed practical nurse (LPN) furnished services in accordance with agency policy in 5 of 12 records reviewed with the potential to affect all patients of the agency who receive services by a licensed practical nurse. (#1, 4, 5, 9, and 10)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Application of Dry Dressing" policy number G-100, dated August 2002 states, "Documentation Guidelines - Document in the clinical record: ... dressing procedure and time of dressing change; wound measurement weekly." 2. The policy titled "Medical Supervision" policy number C-645, revised 10/1/07 states, "Physician will be contacted when any of the following occurs: condition changes, expected 	N0553	<p>At an in-service conducted on 1/21/13 by the Administrator and Director of Professional Services (DPS), all nursing staff were re-educated on the policy and procedure for notifying a physician when there is a change in the patient's condition. This education emphasized the expectation that LPN staff will report changes in patient condition to the supervising RN as well as the Physician. This care coordination will be reflected in the clinical record by a coordination note. Additionally all nursing staff were re-educated on the wound care policy. This education emphasized the expectation that wounds will be measured weekly. A follow up in-service will be held the week of 2/4/12. This in-service will specifically review policy C-645 (Medical Supervision), C-360 (Coordination of Patient Services), G-100, C-680 (clinical documentation) and C-580 (Plan of Care) and nursing job descriptions specifically job responsibilities. The Director of Professional Services will conduct a random audit of 5 client records per week beginning the week of</p>	02/08/2013

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	<p>response to treatment or medication changes ... Any change in patient condition."</p> <p>3. The undated job description titled "Nurse LPN/LVN - HH" states, "Verifies Plan of Care prior to each visit and provides care according to the physician's orders ... Performs ongoing assessment during each visit and documents data in patient medical records. Communications significant findings, problems, or changes in the patient's condition to the supervising RN [registered nurse] and/or Director of Professional Services and the physician and documents all findings, communications and appropriate interventions."</p> <p>4. The policy titled "Coordination of Patient Services" policy number C-360, revised 10/1/07 states, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current care plans; and written and verbal interaction."</p> <p>5. Clinical record #1, start of care</p>		<p>2/4/13 for evidence of weekly wound measurements and that changes in patient condition are being reported to the supervising RN as well as the physician and documented in the clinical record. This process will continue until 100% compliance has been achieved and maintained for 6 consecutive weeks. Thereafter, ongoing compliance will be monitored through the ongoing Quality Improvement process. The Director of Professional services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>				

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	<p>12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week.</p> <p>A. The week of 12/23/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/24/12, 12/26/12, and 12/28/12 failed to evidence any wound measurements were made that week. The LPN, employee EE, made the 12/28/visit.</p> <p>B. . On 1/16/13 at 5:07 PM, employee E, Quality Assurance RN, indicated wounds should be measured weekly.</p> <p>C. On 1/17/13 at 10:00 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented at the start of care on 12/21/12 or the week of 12/23/12.</p> <p>6. Clinical record #4, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower back/hip three times per week. The week of 12/16/12, three skilled nursing</p>			

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	<p>visits were made. Review of the Nursing visit notes from 12/17/12, 12/19/12, and 12/20/12 failed to evidence any wound measurements were made that week.</p> <p>The LPN, employee H, made the 12/19/12 visit.</p> <p>On 1/17/12 at 10:25 AM, employee E, Quality Assurance RN, confirmed no wound measurements were documented the week of 12/16/12.</p> <p>7. Clinical record #5, start of care 12/31/12, contained a home health certification and plan of care dated 12/31/12 - 2/28/13 which states "Changes in patient co-morbid status will be promptly identified and reported to the physician ... Skilled nurse to assess/evaluate ... other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications." Review of the nursing clinical notes evidenced the following:</p> <p>A. On 1/12/13, employee H, LPN, documented under the Respiratory section that the patient had "abnormal breath sounds ... diminished/distant left upper lobe." Review of the clinical record evidenced the LPN failed to notify the supervising RN or attending physician</p>			

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	<p>of the change in patient condition.</p> <p>B. During an interview on 1/16/13 at 3:00 PM, employee II, Director of Nursing, indicated there was no need for the LPN to report the change in condition to the physician or RN. Employee II indicated the LPN was scheduled to see the patient today and would probably just reassess them at that time.</p> <p>C. During an interview on 1/16/13 at 4:30 PM, employee E, Quality Assurance RN, indicated the physician and RN case manager should have been contacted to report the change in condition.</p> <p>8. Clinical record #8, start of care 12/21/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/21/12 to 2/18/13 with orders for skilled nursing to "perform/teach decubitus care to rt [right] buttock and lt [left] buttock above rectal area with NS [normal saline] or wound cleanser. Pat dry with gauze. Cover with hydrocolloid dressing, cover with transparent dressings ... change 3 x [times a] week and PRN [as needed] for soiled or dislodged dressing. Measure weekly and PRN." Review of the Nursing Notes evidenced the following:</p>			

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	<p>The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13, and 1/10/13 failed to evidence any wound measurements were made that week. Employee H, LPN, made the visit on 1/10/13.</p> <p>5. Clinical record #9, start of care 12/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/5/12 to 2/2/13 with orders for skilled nursing to perform decubitus care to buttocks. Review of the Nursing Visit Notes evidenced the following:</p> <p>The week of 12/9/12, two skilled nursing visits were made. Review of the Nursing visit notes from 12/10/12 and 12/13/12 failed to evidence any wound measurements were made that week. Employee EE, LPN, made these visits.</p> <p>9. Clinical record #10, start of care 12/7/12, included a Home Health Certification and Plan of Care for the Certification Period from 12/7/12 to 2/4/13 with orders for skilled nursing to perform wound care to the right lower extremity three times per week. Review of the Nursing Visit Notes evidenced the</p>			

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NAME OF PROVIDER OR SUPPLIER INNOVATIVE SENIOR CARE HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5354 W 62ND ST INDIANAPOLIS, IN 46268
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>following:</p> <p>A. The week of 12/30/12, three skilled nursing visits were made. Review of the Nursing visit notes from 12/31/12, 1/2/13, and 1/4/13, failed to evidence any wound measurements were made that week. Employee EE, LPN, made the visit on 12/31/12.</p> <p>B. The week of 1/6/13, two skilled nursing visits were made. Review of the Nursing visit notes from 1/7/13 and 1/11/13, completed by employee EE, LPN, failed to evidence any wound measurements were made that week.</p>			