

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157048	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER INTERIM HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 605 W EDISON RD STE H MISHAWAKA, IN 46545
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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
G000000	<p>This was a home health federal complaint investigation survey.</p> <p>Complaint #: IN00139994 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey Date: December 5, 2013</p> <p>Facility #: 006118</p> <p>Medicaid #: 200401030A</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 12, 2013</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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G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on clinical record review, policy review, and interview, the agency failed to ensure the home health agency and its staff followed its own policy and procedure regarding missed visits in 2 of 4 clinical records reviewed creating the potential to affect all 178 patients of the agency. (#1 and 2)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 7/14/05, included a plan of care for the certification period 10/7 to 12/05/13 that states, "21. Orders for discipline and treatments ... Services: SN [skilled nursing] 9 hours per day 5 x [times] week" The record failed to evidence a 5th skilled nursing visit was made during week 4 (11/1/13) and failed to evidence documentation to support the patient or caregiver was notified.</p> <p>On 12/5/13 at 4:26 PM, employee B (Registered nurse) indicated there was a call off by staff scheduled to make visit and was unable to locate documentation to support the patient or caregiver was</p>	G000121	G 0121 The Administrator/DHCS has reviewed the agency policy dated 8/27/04 "Variances from the Plan of Care/Service Plan" with RN Nursing Supervisory staff and in-serviced RN Nursing Supervisory staff that in any instance that a variance occurs in the frequency or duration of services from the services ordered in the plan of care, regardless of the reason, that notification of the patient/caregiver is completed at that time and documented in the patient record, and the physician will be notified and documented in the patient record. The documentation will include: 1. reason for the variance (ex: regular staff ill, pt. refused alternate skill matched staff; pt. cancelled all services today because of unexpected out of town company; regular staff ill, pt. declined alternate time for service delivery; unable to locate patient, not home, not answering phone; etc). 2. Type of variance (ex: missed visit or hours provided less than ordered for a treatment week). 3. Who is meeting the patient needs. 4. Who was notified and when notification	12/20/2013			

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	<p>notified.</p> <p>2. Clinical record #2, start of care 8/1/13, included a plan of care for the certification period 9/30 to 11/28/13 that states, "21. Orders for discipline and treatments ... Services: ... HHA [home health aide] 1-7 Hours per week for 9 weeks ... [and] HHA 1-5 visits per week for 9 weeks ..." The record failed to evidence a home health aide visit was made for weeks 7 and 8, and failed to evidence documentation to support the patient or caregiver was notified of either missed visit.</p> <p>On 12/5/13 at 4:12 PM, employee B (Registered nurse) indicated there was no documentation to be located on the missed visits or if the patient was notified.</p> <p>5. The undated agency policy titled "Variances from the Plan of Care/Service Plan" states, "Responsibility The DHCS [director home care services] establishes the expectation and ensures that processes are in place whenever possible to avoid care/service and visit/shift variances from the plan of care/service plan and to manage such appropriately when it occurs. PURPOSE patients/clients receive care/services that they require at the frequency and duration ordered. SCOPE any variance in the delivery of</p>		<p>occurred, and by what method were they notified. RN Supervisors will review daily visit schedules and on-call reports daily for completion of appropriate notification and documentation as outlined above. The RN QA/QI Supervisor will review on a daily basis that this review is completed and documentation appropriate. The Administrator/Director of Health Care Services will be responsible for monitoring these corrective actions weekly and ongoing to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>care/service from the plan of care/service plan ... PROCEDURE visit/shift variance 1. If the office is unable to fill the visit/shift/hour requirement of a patient/client, then the DHCS or designee:</p> <p>a) contacts the patient/client/caregiver to reschedule the visit/shift to comply with the health care practitioner's orders or service plan as established. I) if rescheduling is not an option, the designated employee identifies the patient's/client's on-going needs during this unfilled visit/shift or reduced hours. II) the designated employee identifies alternative measures/means to ensure the patient's/client's needs are met ... b) if alternative means can be engaged to fulfill the patient's/client's needs, all parties including the health care practitioner ... are notified and the notification and alternative means of care/service is documented. c) if alternative means cannot be identified and the visit/shift/hours are not filled but the missed care/services do not put the patient/client at risk, the DHCS or designee notifies all parties including any ordering health care practitioner if applicable and documents such"</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. Based on clinical record review, policy review, and interview, the agency failed to ensure visits and treatments were provided as ordered on the plan of care in 4 of 4 clinical records reviewed creating the potential to affect all 178 patients of the agency. (#1-4)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 7/14/05, included a plan of care for the certification period 10/7 to 12/05/13 that states, "21. Orders for discipline and treatments ... Services: SN [skilled nursing] 9 hours per day 5 x [times] week" The record failed to evidence a 5th skilled nursing visit was made during week 4 (11/1/13).</p> <p>On 12/5/13 at 4:26 PM, employee B (Registered nurse) indicated there was a call off by staff scheduled to make the visit.</p> <p>2. Clinical record #2, start of care 8/1/13, included a plan of care for the certification period 9/30 to 11/28/13 that</p>	G000158	G 158 The Administrator/DHCS has reviewed the policy dated 8/27/04 "Variances from the Plan of Care/Service Plan" and also policy dated 4/4/08 "Developing a Plan to Meet Patient Needs - When Orders For Care Are Required" with the RN Nursing Supervisory Staff and in-serviced RN Nursing Supervisory staff to review daily patient visit schedules on a daily basis for compliance to frequency and duration with regard to physician orders, and to take appropriate follow up/corrective action for any issues identified during this review. The RN QA/QI Supervisor will be responsible for monitoring completion of these reviews, and for the presence of variance reports and caregiver & physician notifications on a daily basis to ensure that this deficiency is corrected and will not recur. The Administrator/DHCS has in-serviced Home Health Aide staff that they must review the care plan upon every visit, and provide all care according to the plan of care on every visit, and that any time the HHA is not able to complete all of the services on the plan of care or a	01/03/2014	

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	<p>states, "21. Orders for discipline and treatments ... Services: ... HHA [home health aide] 1-7 Hours per week for 9 weeks ... HHA 1-5 visits per week for 9 weeks ..." The record failed to evidence a home health aide visit was made for weeks 7 and 8.</p> <p>A. On 12/5/13 at 4:12 PM, employee B (Registered nurse) indicated there was no visit conducted by the home health aide in weeks 7 and 8.</p> <p>B. The record also included orders for the home health aide to provide personal care per home health aide care plan. The document signed by the registered nurse and dated 9/20/13 titled "Home Care Aide Assignment Sheet/Service Plan" states, "Personal Care Bed Bath T [Tuesday], W [Wednesday], Th [Thursday], Sa [Saturday], Su [Sunday] Partial Shower Mon & Fri [Monday and Friday] ... "</p> <p>1.) The record failed to evidence the home health aide completed the task of Shower to patient on 10/11, 10/14, 10/28, 11/4, 11/8, and 11/15/13.</p> <p>2.) The record failed to evidence the home health aide completed the task of Partial Bed Bath to patient on 10/5, 10/16, 10/17, 10/26, 10/30, 10/31, 11/2, and</p>		<p>patient refuses services that the HHA must call in to the RN Supervisor with any change in the plan of care/problems encountered and document why the task was not completed. 100% of all HHA charting will be reviewed weekly by RN Supervisory staff, and ongoing for evidence of the HHA's providing care according to the plan of care and follow up with appropriate corrective action with the HHA. The Administrator/DHCS will be responsible for monitoring these corrective actions weekly and ongoing to ensure that this deficiency is corrected and will not recur. The Administrator/DHCS reviewed the policy dated 8/27/04 "Variances from the Plan of Care/Service Plan" and also policy dated 4/4/08 "Developing a Plan to Meet Patient Needs - When Orders For Care Are Required" with the RN Supervisory Staff and has in-serviced RN Nursing Supervisory staff that in any instance that a variance occurs in the frequency or duration of services from the services ordered in the plan of care, regardless of the reason, that notification of the patient/caregiver is completed at that time and documented in the patient record, and the physician will be notified and documented in the patient record. The documentation will include: 1. reason for the variance</p>				

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	<p>11/7.</p> <p>3.) On 12/5/13 at 4:11 PM, employee B (registered nurse) indicated the home health aide should have documented why the task was not completed and should have called the agency with any change in plan of care.</p> <p>4.) The agency policy dated 4/4/08 titled "Implementing the Plan of Care/Service Plan" states, "POLICY [Agency] provides care/service in accordance with the plan of care/service plan and standards of practice."</p> <p>3. Clinical record #3, start of care 8/14/13, included a plan of care for the certification period 10/13 to 12/11/13 that states, "21. Orders for discipline and treatments ... Services: HHA 5 Hours per day 7 x [times] a week for 8 weeks" The record evidenced home health aide visit for week 3 (10/30/13) with hours of service documented by the home health aide as 2, a home health aide visit for week 4 (11/9/13) with hours of service documented by the home health aide as 3, and a home health aide visit for week 7 (11/28/13) with hours of service documented by the home health aide as 3.</p> <p>On 12/5/13 at 4:20 PM, employee B (Registered nurse) indicated the home</p>		<p>(ex: regular staff ill, pt. refused alternate skill matched staff; pt. cancelled all services today because of unexpected out of town company; regular staff ill, pt. declined alternate time for service delivery; unable to locate patient, not home, not answering phone; etc). 2. Type of variance (ex: missed visit or hours provided less than ordered for a treatment week). 3. Who is meeting the patient needs. 4. Who was notified and when notification occurred, and by what method were they notified. The RN Supervisors will review daily visit schedules and on-call reports daily for completion of appropriate notification and documentation as outlined above. The RN QA/QI Supervisor will be responsible for monitoring completion of these reviews, and for the presence of variance reports and caregiver & physician notifications on a daily basis to ensure that this deficiency is corrected and will not recur. The Administrator/Director of Health Care Services will be responsible for monitoring these corrective actions weekly and ongoing to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>health aide did not complete the 5 hours of ordered services on the dates of 10/30, 11/9, and 11/29/13 and could not locate documentation to support why the hours were not provided.</p> <p>4. Clinical record #4, start of care 10/3/13, included a plan of care for the certification period 10/3 to 12/01/13 that states, "21. Orders for discipline and treatments ... Services: HHA 4-8 Hours per day 5-7 x a week for 9 weeks" The record evidenced a home health aide visit for week 1 (10/5/13) with hours of service documented by the home health aide as 2 and a 4th home health aide visit for week 2 (10/10/13) with hours of service documented by the home health aide as 2.</p> <p>On 12/5/13 at 3:50 PM, employee B (Registered nurse) indicated the home health aide provided 2 hours of services on 10/5 and 10/10/13 and was unable to locate documentation of why the visit hours made were less than the ordered amount.</p> <p>5. The undated agency policy titled "Variances from the Plan of Care/Service Plan" states, "Responsibility The DHCS [director home care services] establishes the expectation and ensures that processes are in place whenever possible to avoid care/service and visit/shift variances from</p>				

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	<p>the plan of care/service plan and to manage such appropriately when it occurs. PURPOSE patients/clients receive care/services that they require at the frequency and duration ordered. SCOPE any variance in the delivery of care/service from the plan of care/service plan ... PROCEDURE visit/shift variance 1. If the office is unable to fill the visit/shift/hour requirement of a patient/client, then the DHCS or designee: a) contacts the patient/client/caregiver to reschedule the visit/shift to comply with the health care practitioner's orders or service plan as established. I) if rescheduling is not an option, the designated employee identifies the patient's/client's on-going needs during this unfilled visit/shift or reduced hours. II) the designated employee identifies alternative measures/means to ensure the patient's/client's needs are met ... b) if alternative means can be engaged to fulfill the patient's/client's needs, all parties including the health care practitioner ... are notified and the notification and alternative means of care/service is documented. c) if alternative means cannot be identified and the visit/shift/hours are not filled but the missed care/services do not put the patient/client at risk, the DHCS or designee notifies all parties including any ordering health care practitioner if</p>						

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	applicable and documents such ... "			

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G000236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure a discharge summary was completed in 1 of 2 discharged records reviewed creating the potential to affect all patients of the agency. (#2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2 start of care 8/1/13 and discharge date of 11/17/13, failed to evidence a discharge summary. 2. On 12/5/13 at 4:04 PM, employee B (registered nurse) indicated there was no discharge summary for this patient. 	G000236	G0236 The Administrator/DHCS has in-serviced RN Nursing Supervisory staff to notify the physician and complete the discharge summary within 48 hours of the agency learning of the discharge. The RN QA/QI Supervisor will continue to monitor 100% of discharges to ensure that the RN's notify the physician and complete the discharge summary within 48 hours of the agency learning of the discharge. The Administrator/DHCS will be responsible for monitoring these corrective actions weekly and ongoing to ensure that this deficiency is corrected and will not recur.	12/17/2013			

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N000000	<p>This was a home health state complaint investigation survey.</p> <p>Complaint #: IN00139994 - Substantiated: State deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey Date: December 5, 2013</p> <p>Facility #: 006118</p> <p>Medicaid #: 200401030A</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: right;">December 12, 2013</p>	N000000			

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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, policy review, and interview, the agency failed to ensure visits were provided as ordered on the plan of care in 4 of 4 clinical records reviewed creating the potential to affect all 178 patients of the agency. (#1-4)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 7/14/05, included a plan of care for the certification period 10/7 to 12/05/13 that states, "21. Orders for discipline and treatments ... Services: SN [skilled nursing] 9 hours per day 5 x [times] week" The record failed to evidence a 5th skilled nursing visit was made during week 4 (11/1/13).</p> <p>On 12/5/13 at 4:26 PM, employee B (Registered nurse) indicated there was a call off by staff scheduled to make the visit.</p> <p>2. Clinical record #2, start of care 8/1/13, included a plan of care for the certification period 9/30 to 11/28/13 that</p>	N000522	N 0522The Administrator/DHCS has in-serviced RN Nursing Supervisory staff to review daily patient visit schedules on a daily basis for compliance to frequency and duration with regard to physician orders, and to take appropriate follow up/corrective action for any issues identified during this review. The RN QA/QI Supervisor will be responsible for monitoring completion of these reviews, and for the presence of variance reports and caregiver & physician notifications on a daily basis to ensure that this deficiency is corrected and will not recur. The Administrator/DHCS will be responsible for monitoring these corrective actions weekly and ongoing to ensure that this deficiency is corrected and will not recur. The Administrator/DHCS has reviewed the agency policy dated 8/27/04 "Variances from the Plan of Care/Service Plan" with the RN Supervisory Staff and in-serviced RN Nursing Supervisory staff that in any instance that a variance occurs in the frequency or duration of services from the services ordered in the plan of care,	12/20/2013			

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	<p>states, "21. Orders for discipline and treatments ... Services: ... HHA [home health aide] 1-7 Hours per week for 9 weeks ... HHA 1-5 visits per week for 9 weeks ..." The record failed to evidence a home health aide visit was made for weeks 7 and 8.</p> <p>On 12/5/13 at 4:12 PM, employee B (Registered nurse) indicated there was no visit conducted by the home health aide in weeks 7 and 8.</p> <p>3. Clinical record #3, start of care 8/14/13, included a plan of care for the certification period 10/13 to 12/11/13 that states, "21. Orders for discipline and treatments ... Services: HHA 5 Hours per day 7 x [times] a week for 8 weeks" The record evidenced home health aide visit for week 3 (10/30/13) with hours of service documented by the home health aide as 2, a home health aide visit for week 4 (11/9/13) with hours of service documented by the home health aide as 3, and a home health aide visit for week 7 (11/28/13) with hours of service documented by the home health aide as 3.</p> <p>On 12/5/13 at 4:20 PM, employee B (Registered nurse) indicated the home health aide did not complete the 5 hours of ordered services on the dates of 10/30, 11/9, and 11/29/13 and could not locate</p>		<p>regardless of the reason, that notification of the patient/caregiver is completed at that time and documented in the patient record, and the physician will be notified and documented in the patient record. The documentation will include: 1. reason for the variance (ex: regular staff ill, pt. refused alternate skill matched staff; pt. cancelled all services today because of unexpected out of town company; regular staff ill, pt. declined alternate time for service delivery; unable to locate patient, not home, not answering phone; etc). 2. Type of variance (ex: missed visit or hours provided less than ordered for a treatment week). 3. Who is meeting the patient needs. 4. Who was notified and when notification occurred, and by what method were they notified. The RN QA/QI Supervisor will be responsible for monitoring completion of these reviews, and for the presence of variance reports and caregiver & physician notifications on a daily basis to ensure that this deficiency is corrected and will not recur. The Administrator/Director of Health Care Services will be responsible for monitoring these corrective actions weekly and ongoing to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>documentation to support why the hours were not provided.</p> <p>4. Clinical record #4, start of care 10/3/13, included a plan of care for the certification period 10/3 to 12/01/13 that states, "21. Orders for discipline and treatments ... Services: HHA 4-8 Hours per day 5-7 x a week for 9 weeks" The record evidenced a home health aide visit for week 1 (10/5/13) with hours of service documented by the home health aide as 2 and a 4th home health aide visit for week 2 (10/10/13) with hours of service documented by the home health aide as 2.</p> <p>On 12/5/13 at 3:50 PM, employee B (Registered nurse) indicated the home health aide provided 2 hours of services on 10/5 and 10/10/13 and was unable to locate documentation of why the visit hours made were less than the ordered amount.</p> <p>5. The undated agency policy titled "Variances from the Plan of Care/Service Plan" states, "Responsibility The DHCS [director home care services] establishes the expectation and ensures that processes are in place whenever possible to avoid care/service and visit/shift variances from the plan of care/service plan and to manage such appropriately when it occurs. PURPOSE patients/clients</p>			

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	<p>receive care/services that they require at the frequency and duration ordered.</p> <p>SCOPE any variance in the delivery of care/service from the plan of care/service plan ... PROCEDURE visit/shift variance</p> <p>1. If the office is unable to fill the visit/shift/hour requirement of a patient/client, then the DHCS or designee:</p> <p>a) contacts the patient/client/caregiver to reschedule the visit/shift to comply with the health care practitioner's orders or service plan as established. I) if rescheduling is not an option, the designated employee identifies the patient's/client's on-going needs during this unfilled visit/shift or reduced hours.</p> <p>II) the designated employee identifies alternative measures/means to ensure the patient's/client's needs are met ... b) if alternative means can be engaged to fulfill the patient's/client's needs, all parties including the health care practitioner ... are notified and the notification and alternative means of care/service is documented. c) if alternative means cannot be identified and the visit/shift/hours are not filled but the missed care/services do not put the patient/client at risk, the DHCS or designee notifies all parties including any ordering health care practitioner if applicable and documents such"</p>				

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N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure a discharge summary was completed in 1 of 2 discharged records reviewed creating the potential to affect all patients of the agency. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2 start of care 8/1/13 and discharge date of 11/17/13, failed to evidence a discharge summary.</p> <p>2. On 12/5/13 at 4:04 PM, employee B (registered nurse) indicated there was no discharge summary for this patient.</p>	N000608	The Administrator/DHCS has in-serviced RN Nursing Supervisory staff to notify the physician and complete the discharge summary within 48 hours of the agency learning of the discharge. The RN QA/QI Supervisor will continue to monitor 100% of discharges to ensure that the RN's notify the physician and complete the discharge summary within 48 hours of the agency learning of the discharge. The Administrator/DHCS will be responsible for monitoring these corrective actions weekly and ongoing to ensure that this deficiency is corrected and will not recur.	12/17/2013			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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