

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
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NAME OF PROVIDER OR SUPPLIER OPTION HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9111 BROADWAY STE AA MERRILLVILLE, IN 46410
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G0000	<p>This visit was a home health federal recertification survey. This visit resulted in a partial extended survey.</p> <p>Survey dates: 5-18-12, 5-21-12, 5-22-12, and 5-23-12</p> <p>Facility #: IN008882</p> <p>Medicaid Vendor: 200034260</p> <p>Surveyor: Ingrid Miller, PHNS, RN</p> <p>Skilled unduplicated census: 179 skilled patients, 0 home health aide only patients, 0 personal service patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 29, 2012</p>	G0000		

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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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on home visit observation, interview, and policy review, the agency failed to ensure 2 of 2 Registered Nurses (Employees B and C) observed at 3 of 6 home visits (patients 1, 2, and 4) followed infection control agency policy with the potential to affect all the agency patients.</p> <p>Findings</p> <p>1. At a home visit on 5/21/12 at 10:30 AM, Employee B, Registered Nurse (RN), was observed to perform a left foot ulcer dressing change with Patient #1. Employee B washed hands and put on gloves before removing the soiled dressing and then changed gloves before cleansing and dressing the wound. No handwashing occurred after the soiled dressing was removed; the dirty gloves were removed and the clean gloves donned. Employee B placed the nursing bag, a large toolbox, on the patient's couch without a barrier. While assessing the vital signs, Employee B did not clean the blood pressure cuff or stethoscope after use and before returning to the nursing bag.</p>	G0121	G01211. Update our Infection Control Policy.2. Nurses will be supplied with newspaper to be placed under boxes.3. Inservice on gloving and infection control will be performed.4. Nurses will be supplies with alcohol wipes and/or other wipes to clean equipment before placing back into box.5. Director of Nursing will monitor home visits for compliance.	06/22/2012

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	<p>2. At a home visit on 5/21/12 at 12:30 PM, Employee C, RN, was observed to perform an abdominal wound dressing change on Patient #2. Employee C washed hands and donned gloves, removed the old dressing and, without washing hands at this time, donned clean gloves and proceeded with cleansing and dressing the wound. Employee C placed the nursing bag, a large toolbox, on the patient's bed with no barrier between the nursing toolbox and the bed.</p> <p>3. At a home visit on 5/21/12 at 2 PM, Employee C was observed to place the nursing tool box on a chair near Patient #4. Employee C did not place a barrier between the nursing bag and the chair. After assessing the patient's blood pressure and apical heart rate, Employee C did not clean the blood pressure cuff or stethoscope before returning the equipment to the nursing bag.</p> <p>4. On 5/21/12 at 3:10 PM, Employee B indicated the infection control policy was not followed at the above visits.</p> <p>5. The agency policy titled "Infection / Exposure Control Program" with a date of 06/2006 stated, "Always place the nursing bag on a clean area or put newspaper or paper toweling, which can be discarded,</p>				

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	under the bag to prevent cross contamination ... decontaminate hands before and after wearing gloves ... Reusable items must be cleaned if visibly soiled before placing back in bag. Clean the stethoscope diaphragm with an alcohol swab. Spray blood pressure cuff with disinfectant or use disposable cover if indicated."			

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G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on home visit observation, clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all required elements for 8 of 12 clinical records reviewed including a complete and accurate list of medications, a timely physician signature, a verbal order date, and diagnosis relevant to care (Clinical record #1, #2, #4, #5, #6, #9, #11, and #12) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 4/27/12 with a certification period of 4/27/12 - 6/25/12, failed to evidence a complete and accurate list of medications on the plan of care (POC). The clinical document titled "Home Health Certification and Plan of Care" for the certification period of 4/27/12 - 6/25/12</p>	G0159	G 0159#11. The R.N. will get the name of the drug - dose - frequency and route of administration on admission and also when a new medication is started.2. All nurses will receive an Inservice on this requirement.3. The Director of Nursing will monitor this process with chart reviews upon discharge or with an active chart at least a minimum of 10% quarterly.#21. All Home Health Certification and Plan of Care documents will indicate nursing visits for 9 weeks.2. Director of Nursing will monitor this with chart reviews.#31. All Home Health Certification and Plan of Care documents will have the care that the patient will receive included in the document.2. All care will be specific to size and frequency of certain procedures.3. All Home Health Certification and Plan of Care documents will include teaching orders.4. The Director of Nursing will monitor this requirement with	06/22/2012			

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	<p>and signed by Employee B, Registered Nurse (RN) and director of nursing on 4/27/12 stated, "Medications: Dose / Frequency / Route ... Novolog SQ [subcutaneous]." This document failed to evidence the dose and frequency of novolog insulin to be given at certain blood sugar levels with the sliding scale.</p> <p>a. On 5/21/12 at 3:15 PM, Employee B, the director of nursing indicated the current POC did not include the amount of insulin to be given at certain blood sugar levels with the sliding scale.</p> <p>b. The agency policy titled "Physician Orders" with a date of 4/2011 stated, "All orders for pharmaceuticals shall include the following: name of drug, dosage, frequency of administration, method of administration, flush orders ... HCFA Forms 485 ... may be used instead of, or in addition to, other Option Healthcare Physician Orders forms."</p> <p>2. Clinical record #2, SOC 3/15/12 with a certification period of 3/15/12 - 5/13/12, failed to evidence the POC was complete and duration of visits as required. The clinical document titled "Home Health Certification and Plan of Care" for the certification period of 3/15/12 - 5/13/12 and signed by Employee AC on 3/15/12</p>		<p>chart reviews.#41. All orders written or verbal will be signed and dated by the R.N.2. Director of Nursing will monitor with chart reviews.3. All staff will be informed.#51. All orders written or verbal will be signed and dated by the R.N. 2. Director of Nursing will monitor with chart reviews.3. All staff will be informed.#61. All orders written or verbal will be signed and dated by the R.N.2. Director of Nursing will monitor with chart reviews.3. All staff will be informed.#7, #8, #91. Option Healthcare will accept faxed orders, dated and signed.2. Doctor's office will be called to inform that a fax has been sent.3. Follow-up will be made with the physician's office via phone call if the orders are not received back within 48 hours.4. Director of Nursing will monitor this requirement with chart reviews.5. If the physician omits entering the date, Option Healthcare will use the date printed on the fax received as the date returned.6. In order to verify that orders are being faxed and follow-up is being made; the fax cover sheet will be used to document dates, times, correspondence and will be retained in a pending file. If orders are outside the 14 days when returned, the fax cover sheet will be filed in the patient's chart as documentation.</p>		

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	<p>failed to indicate the duration of visits to be made by the skilled nurse. The document stated, "Orders for Discipline and Treatment (Specify amount / frequency / duration) ... SN [skilled nurse] 3 to 5 / wk X 1 week [3 to 5 times a week for 1 week] SN 2 to 4 /wk. [2 to 4 times a week.]" There was no indication of the duration of the final weeks of SN care.</p> <p>On 5/21/12 at 4:30 PM, Employee B indicated the visit duration was only listed for the first week and not the final 8 weeks of care.</p> <p>3. Clinical record #4, SOC 2/24/12, included a plan of care for the certification period of 4/24/12 - 5/22/12 that failed to include the patient had an ileostomy and urostomy. At a home visit on 5/21/12 at 2 PM, Employee C was observed assessing the patency of two collection bags on the patient's abdominal area.</p> <p>a. On 5/21/12 at 3:15 PM, Employee C indicated the patient #4 had an ileostomy and urostomy.</p> <p>b. On 5/22/12 at 3:40 PM, Employee B indicated POC failed to include the patient had an ileostomy and urostomy.</p>						

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	<p>c. The clinical document titled "Intermediate Patient Progress Record" with a date of 5/17/12 and signature of Employee B stated, "Genitourinary - Urostomy changes bag daily ... Gastrointestinal ileostomy empties 2 - 3 times / day. Output depends on diet."</p> <p>4. Clinical record #5, SOC 1/1/12, included a POC for the certification period of 2/29/12 - 4/28/12 that failed to include a verbal order date. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 2/29/12 - 4/28/12 and signed by Employee B failed to indicate a date of the verbal orders.</p> <p>On 5/22/12 at 4:05 PM, Employee B indicated the POC lacked a verbal order date.</p> <p>5. Clinical record #6, SOC 9/20/10, included a POC for the certification period of 3/13/12 -5/11/12 that failed to include a verbal order date. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 3/13/12 - 5/11/12 and signed by Employee B failed to indicate a date of the verbal orders.</p> <p>On 5/22/12 at 3:55 PM, Employee B indicated the POC lacked a verbal order</p>				

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	<p>date.</p> <p>6. Clinical record #9, SOC 5/1/12, included a POC for the certification period of 5/1/12 - 6/28/12 that failed to include a verbal order date. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 5/1/12 - 6/28/12 signed by Employee B failed to indicate a date of the verbal orders.</p> <p>On 5/22/12 at 3:55 PM, Employee B indicated the POC lacked a verbal order date.</p> <p>7. Clinical record #11, SOC 1/6/12, included a POC for the certification period of 1/6/12 - 3/5/12 lacked a timely signature by the physician. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 1/6/12 - 3/5/12 and signed by Employee B on 1/4/12 evidenced a physician's signature on 2/28/12.</p> <p>On 5/23/12 at 1 PM, Employee B indicated the POC lacked a timely physician signature.</p> <p>8. Clinical record #12, SOC 11/11/11, included a POC for the certification period of 11/11/11 - 1/9/12 lacked a</p>			

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	<p>timely signature by the physician. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 11/11/12 and signed by Employee L on 11/11/11 evidenced a physician's signature on 12/13/11.</p> <p>On 5/23/12 at 12:15 PM, Employee B indicated the POC lacked a timely physician signature.</p> <p>9. The agency policy titled "Option Healthcare description of items contained on Form CMS - 485 MF-45 with a review date of 3/10/11 stated, "Policy: To accurately complete the HCFA - 485 ... Enter all pertinent diagnosis, both narrative and ICD-9-CM codes relevant to the care rendered ... the physician must specify the frequency and the expected duration of the visits for each discipline ... Nurse's signature and date of verbal start of care this verifies for surveyors, CMS representatives, and the RHHI that a registered nurse ... responsible for furnishing or supervising the patient's care, spoke to the attending physician and received verbal authorization to visit the patient."</p> <p>10. The agency policy titled "Physician Orders" with a date of 4/2011 stated, "Orders shall be signed by the physician</p>						

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	within 14 working days of the order date."				

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G0337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the medication profile was complete for 1 of 12 clinical records reviewed (Clinical Record #1) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/27/12 with a certification period of 4/27/12 - 6/25/12, failed to evidence a complete and accurate medication profile. The clinical document titled "Medication Profile" signed by Employee C, Registered Nurse, on 5/10/12 stated, "Start Date 4/27/12 and End Date 6/25/12 Novolog SQ [subcutaneous] prn [as needed] per sliding scale." The sliding scale was not included on the medication profile.</p> <p>On 5/21/12 at 3:15 PM, Employee B, the director of nursing, indicated the</p>	G0337	G 0337#11. The R.N. will obtain the name of the medication - dose - frequency and route of administration upon admission and when a medication is added or changed.2. All Nurses will be inserviced on this policy.3. The Director of Nursing will monitor with chart reviews upon discharge and with active charts at least 10% quarterly.#21. The R.N. will obtain the name of the medication - dose - frequency and route of administration upon admission and when a medication is added or changed.2. All Nurses will be inserviced on this policy.3. The Director of Nursing will monitor with chart reviews upon discharge and with active charts at least 10% quarterly.#31. The R.N. will obtain the name of the medication - dose - frequency and route of administration upon admission and when a medication is added or changed.2. All Nurses will be inserviced on this policy.3. The Director of Nursing will monitor	06/22/2012			

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	<p>medication profile did not include the sliding scale for the amount of Novolog insulin to be given for identified blood sugar levels.</p> <p>2. The agency policy titled "Medication Profile" dated 1/2008 stated, "To provide the Option Healthcare RN and physician with a current list of medication ... Doses, frequencies and routes will also be listed."</p> <p>3. The agency policy titled "Policy on Blood Sugars" with a date of 3/2011 stated, "Document sliding scale in medication profile."</p>		with chart reviews upon discharge and with active charts at least 10% quarterly.		

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G0339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the comprehensive assessment was updated and revised the last 5 days of the certification period for 1 of 12 active clinical records reviewed (Clinical record #5) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #5, start of care 1/1/12, certification periods of 2/29/12 and 4/28/12 and 4/29/12 - 6/27/12, failed to evidence a comprehensive assessment had been completed during the last 5 days of the previous certification period. The clinical document titled "Oasis-C Recertification w/notes [with notes]" with a date of 4/30/12 and signed by Employee B failed to be completed prior to the certification period of 4/29/12 - 6/27/12.</p> <p>On 5/22/12 at 4:05 PM, Employee B,</p>	G0339	G 0339#11. Nurses will be inserviced regarding OASIS and timely recertification.2. All Non-Medicare and Non-Medicaid patients will follow our Comprehensive Assessment Policy APP-4B in our Policy and Procedure Manual.3. The Director of Nursing will monitor this requirement with chart reviews.#21. Nurses will be inserviced regarding OASIS and timely recertification.2. All Non-Medicare and Non-Medicaid patients will follow our Comprehensive Assessment Policy APP-4B in our Policy and Procedure Manual.	06/22/2012			

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	<p>the director of nursing and RN, indicated the oasis was completed late.</p> <p>2. The agency policy titled "Oasis Assessment Forms" with a date of 4/10/09 stated, "Follow-up assessment ... This form must be completed within a five-day period immediately preceding the end of the current certification period."</p>						

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on home visit observation, interview, and policy review, the agency failed to ensure 2 of 2 Registered Nurses (Employees B and C) observed at 3 of 6 home visits (patients 1, 2, and 4) followed infection control agency policy with the potential to affect all the agency patients.</p> <p>Findings</p> <p>1. At a home visit on 5/21/12 at 10:30 AM, Employee B, Registered Nurse (RN), was observed to perform a left foot ulcer dressing change with Patient #1. Employee B washed hands and put on gloves before removing the soiled dressing and then changed gloves before cleansing and dressing the wound. No handwashing occurred after the soiled dressing was removed; the dirty gloves were removed and the clean gloves donned. Employee B placed the nursing bag, a large toolbox, on the patient's couch without a barrier. While assessing the vital signs, Employee B did not clean the blood pressure cuff or stethoscope after use and before returning to the</p>	N0470	<p>N 0470#11. Update our Infection Control Policy.2. Option Healthcare will provide all nurses with newspaper to be placed under boxes.3. Inservice will be given on gloving and infection control.4. Option Healthcare will supply nurses with alcohol wipes and/or other wipes to clean equipment before placing back in box.5. The Director of Nursing will monitor home visits for compliance.#21. Update our Infection Control Policy.2. Option Healthcare will provide all nurses with newspaper to be placed under boxes.3. Inservice will be given on gloving and infection control.4. Option Healthcare will supply nurses with alcohol wipes and/or other wipes to clean equipment before placing back in</p>	06/22/2012

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	<p>nursing bag.</p> <p>2. At a home visit on 5/21/12 at 12:30 PM, Employee C, RN, was observed to perform an abdominal wound dressing change on Patient #2. Employee C washed hands and donned gloves, removed the old dressing and, without washing hands at this time, donned clean gloves and proceeded with cleansing and dressing the wound. Employee C placed the nursing bag, a large toolbox, on the patient's bed with no barrier between the nursing toolbox and the bed.</p> <p>3. At a home visit on 5/21/12 at 2 PM, Employee C was observed to place the nursing tool box on a chair near Patient #4. Employee C did not place a barrier between the nursing bag and the chair. After assessing the patient's blood pressure and apical heart rate, Employee C did not clean the blood pressure cuff or stethoscope before returning the equipment to the nursing bag.</p> <p>4. On 5/21/12 at 3:10 PM, Employee B indicated the infection control policy was not followed at the above visits.</p> <p>5. The agency policy titled "Infection / Exposure Control Program" with a date of 06/2006 stated, "Always place the nursing bag on a clean area or put newspaper or</p>		<p>box.5. The Director of Nursing will monitor home visits for compliance.#4.1. Update our Infection Control Policy.2. Option Healthcare will provide all nurses with newspaper to be placed under boxes.3. Inservice will be given on gloving and infection control.4. Option Healthcare will supply nurses with alcohol wipes and/or other wipes to clean equipment before placing back in box.5. The Director of Nursing will monitor home visits for compliance.#5.1. Update our Infection Control Policy.2. Option Healthcare will provide all nurses with newspaper to be placed under boxes.3. Inservice will be given on gloving and infection control.4. Option Healthcare will supply nurses with alcohol wipes and/or other wipes to clean equipment before placing back in box.5. The Director of Nursing will monitor home visits for compliance.</p>		

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	paper toweling, which can be discarded, under the bag to prevent cross contamination ... decontaminate hands before and after wearing gloves ... Reusable items must be cleaned if visibly soiled before placing back in bag. Clean the stethoscope diaphragm with an alcohol swab. Spray blood pressure cuff with disinfectant or use disposable cover if indicated."			

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on home visit observation, clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all required elements for 8 of 12 clinical records reviewed including a complete and accurate list of medications, a timely physician signature, a verbal order date, and diagnosis relevant to care (Clinical record #1, #2, #4, #5, #6, #9, #11, and #12) with the potential to affect all the agency's patients.</p>	N0524	N 0524#11. The R.N. will obtain the name of the medication - drug - dose - frequency and route of administration on admission and when a medication is added or changed.2. All Nurses will be inservices on this requirement.3. The Director of Nursing will monitor with chart reviews upon discharge or with active charts at least 10% quarterly.#21. Home Health Certification and Plan of Care documents will indicate nursing visits for 9 weeks.2. The Director of Nursing	06/22/2012			

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	<p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 4/27/12 with a certification period of 4/27/12 - 6/25/12, failed to evidence a complete and accurate list of medications on the plan of care (POC). The clinical document titled "Home Health Certification and Plan of Care" for the certification period of 4/27/12 - 6/25/12 and signed by Employee B, Registered Nurse (RN) and director of nursing on 4/27/12 stated, "Medications: Dose / Frequency / Route ... Novolog SQ [subcutaneous]." This document failed to evidence the dose and frequency of novolog insulin to be given at certain blood sugar levels with the sliding scale.</p> <p>a. On 5/21/12 at 3:15 PM, Employee B, the director of nursing indicated the current POC did not include the amount of insulin to be given at certain blood sugar levels with the sliding scale.</p> <p>b. The agency policy titled "Physician Orders" with a date of 4/2011 stated, "All orders for pharmaceuticals shall include the following: name of drug, dosage, frequency of administration, method of administration, flush orders ... HCFA Forms 485 ... may be used instead</p>		<p>will monitor this requirement with chart reviews.#31. The Home Health Certification and Plan of Care document will have the care the patient will receive.2. All patient plan of care will be specific as to sizes and frequency of certain procedure.3. All Home Health Certification and Plan of Care will include teaching orders.4. The Director of Nursing will monitor requirement with chart reviews.#41. All orders written or verbal will be signed and dated by the R.N.2. The Director of Nursing will monitor this requirement with chart reviews.3. The Staff will be reminded to follow this policy.#51. All orders written or verbal will be signed and dated by the R.N.2. The Director of Nursing will monitor this requirement with chart reviews.3. The Staff will be reminded to follow this policy.#6.1. All orders written or verbal will be signed and dated by the R.N.2. The Director of Nursing will monitor this requirement with chart reviews.3. The Staff will be reminded to follow this policy.#71. All orders written or verbal will be signed and dated by the R.N.2. The Director of Nursing will monitor this requirement with chart reviews.3. The Staff will be informed.#81. Option Healthcare now accepting faxed orders dated and signed. 2. A phone call will be made to the physician's office to notify</p>				

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	<p>of, or in addition to, other Option Healthcare Physician Orders forms."</p> <p>2. Clinical record #2, SOC 3/15/12 with a certification period of 3/15/12 - 5/13/12, failed to evidence the POC was complete and duration of visits as required. The clinical document titled "Home Health Certification and Plan of Care" for the certification period of 3/15/12 - 5/13/12 and signed by Employee AC on 3/15/12 failed to indicate the duration of visits to be made by the skilled nurse. The document stated, "Orders for Discipline and Treatment (Specify amount / frequency / duration) ... SN [skilled nurse] 3 to 5 / wk X 1 week [3 to 5 times a week for 1 week] SN 2 to 4 /wk. [2 to 4 times a week.]" There was no indication of the duration of the final weeks of SN care.</p> <p>On 5/21/12 at 4:30 PM, Employee B indicated the visit duration was only listed for the first week and not the final 8 weeks of care.</p> <p>3. Clinical record #4, SOC 2/24/12, included a plan of care for the certification period of 4/24/12 - 5/22/12 that failed to include the patient had an ileostomy and urostomy. At a home visit on 5/21/12 at 2 PM, Employee C was observed assessing the patency of two</p>		<p>them a fax is being sent.3. A follow-up call will be made to the physician's office if the order has not been returned within 48 hours.4. The Director of Nursing will monitor with chart reviews.5. If the order received is not dated by the physician, Option Healthcare will use the date received on the faxed order as the date signed.6. In order to verify that orders are being faxed and follow-up is being made; the fax cover sheet will be used to document dates, times, correspondence and will be retained in a pending file. If orders are outside the 14 days when returned, the fax cover sheet will be filed in the patient's chart as documentation.#91. Option Healthcare now accepting faxed orders dated and signed. 2. A phone call will be made to the physician's office to notify them a fax is being sent.3. A follow-up call will be made to the physician's office if the order has not been returned within 48 hours.4. The Director of Nursing will monitor with chart reviews.5. If the order received is not dated by the physician, Option Healthcare will use the date received on the faxed order as the date signed.6. In order to verify that orders are being faxed and follow-up is being made; the fax cover sheet will be used to document dates, times, correspondence and will be retained in a pending file. If</p>				

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	<p>collection bags on the patient's abdominal area.</p> <p>a. On 5/21/12 at 3:15 PM, Employee C indicated the patient #4 had an ileostomy and urostomy.</p> <p>b. On 5/22/12 at 3:40 PM, Employee B indicated POC failed to include the patient had an ileostomy and urostomy.</p> <p>c. The clinical document titled "Intermediate Patient Progress Record" with a date of 5/17/12 and signature of Employee B stated, "Genitourinary - Urostomy changes bag daily ... Gastrointestinal ileostomy empties 2 - 3 times / day. Output depends on diet."</p> <p>4. Clinical record #5, SOC 1/1/12, included a POC for the certification period of 2/29/12 - 4/28/12 that failed to include a verbal order date. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 2/29/12 - 4/28/12 and signed by Employee B failed to indicate a date of the verbal orders.</p> <p>On 5/22/12 at 4:05 PM, Employee B indicated the POC lacked a verbal order date.</p> <p>5. Clinical record #6, SOC 9/20/10,</p>		<p>orders are outside the 14 days when returned, the fax cover sheet will be filed in the patient's chart as documentation.#101. Option Healthcare now accepting faxed orders dated and signed.</p> <p>2. A phone call will be made to the physician's office to notify them a fax is being sent.3. A follow-up call will be made to the physician's office if the order has not been returned within 48 hours.4. The Director of Nursing will monitor with chart reviews.5. If the order received is not dated by the physician, Option Healthcare will use the date received on the faxed order as the date signed.6. In order to verify that orders are being faxed and follow-up is being made; the fax cover sheet will be used to document dates, times, correspondence and will be retained in a pending file. If orders are outside the 14 days when returned, the fax cover sheet will be filed in the patient's chart as documentation.</p>		

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	<p>included a POC for the certification period of 3/13/12 -5/11/12 that failed to include a verbal order date. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 3/13/12 - 5/11/12 and signed by Employee B failed to indicate a date of the verbal orders.</p> <p>On 5/22/12 at 3:55 PM, Employee B indicated the POC lacked a verbal order date.</p> <p>6. Clinical record #9, SOC 5/1/12, included a POC for the certification period of 5/1/12 - 6/28/12 that failed to include a verbal order date. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 5/1/12 - 6/28/12 signed by Employee B failed to indicate a date of the verbal orders.</p> <p>On 5/22/12 at 3:55 PM, Employee B indicated the POC lacked a verbal order date.</p> <p>7. Clinical record #11, SOC 1/6/12, included a POC for the certification period of 1/6/12 - 3/5/12 lacked a timely signature by the physician. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 1/6/12 - 3/5/12</p>						

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	<p>and signed by Employee B on 1/4/12 evidenced a physician's signature on 2/28/12.</p> <p>On 5/23/12 at 1 PM, Employee B indicated the POC lacked a timely physician signature.</p> <p>8. Clinical record #12, SOC 11/11/11, included a POC for the certification period of 11/11/11 - 1/9/12 lacked a timely signature by the physician. The clinical document titled "Home Health Certification Period and Plan of Care" for the certification period of 11/11/12 and signed by Employee L on 11/11/11 evidenced a physician's signature on 12/13/11.</p> <p>On 5/23/12 at 12:15 PM, Employee B indicated the POC lacked a timely physician signature.</p> <p>9. The agency policy titled "Option Healthcare description of items contained on Form CMS - 485 MF-45 with a review date of 3/10/11 stated, "Policy: To accurately complete the HCFA - 485 ... Enter all pertinent diagnosis, both narrative and ICD-9-CM codes relevant to the care rendered ... the physician must specify the frequency and the expected duration of the visits for each discipline ... Nurse's signature and date of verbal start</p>						

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	<p>of care this verifies for surveyors, CMS representatives, and the RHHI that a registered nurse ... responsible for furnishing or supervising the patient's care, spoke to the attending physician and received verbal authorization to visit the patient."</p> <p>10. The agency policy titled "Physician Orders" with a date of 4/2011 stated, "Orders shall be signed by the physician within 14 working days of the order date."</p>			

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N0541	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse reevaluated the patient's needs with the completion of a comprehensive assessment during the last 5 days of the certification period for 1 of 12 active clinical records reviewed (Clinical record #5).</p> <p>Findings</p> <p>1. Clinical record #5, start of care 1/1/12, certification periods of 2/29/12 and 4/28/12 and 4/29/12 - 6/27/12, failed to evidence a comprehensive assessment had been completed during the last 5 days of the previous certification period. The clinical document titled "Oasis-C Recertification w/notes [with notes]" with a date of 4/30/12 and signed by Employee B failed to be completed prior to the certification period of 4/29/12 - 6/27/12.</p> <p>On 5/22/12 at 4:05 PM, Employee B, the director of nursing and RN, indicated the oasis was completed late.</p>	N0541	<p>N 0541#11. Nurses will be inserviced regarding OASIS and timely recertification.2. All Non-Medicare and Non-Medicaid patients will follow our Comprehensive Assessment Policy APP-4B in our Policy and Procedure Manual.3. The Director of Nursing will monitor this requirement with chart reviews.#21. Nurses will be inserviced regarding OASIS and timely recertification.2. All Non-Medicare and Non-Medicaid patients will follow our Comprehensive Assessment Policy APP-4B in our Policy and Procedure Manual.3. The Director of Nursing will monitor this requirement with chart reviews.</p>	06/22/2012

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	2. The agency policy titled "Oasis Assessment Forms" with a date of 4/10/09 stated, "Follow-up assessment ... This form must be completed within a five-day period immediately preceding the end of the current certification period."			