

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 W LINCOLN HWY MERRILLVILLE, IN 46410
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N000000	<p>This visit was for a home health agency state relicensure survey.</p> <p>Survey dates: June 10 - 13, 2013</p> <p>Facility #: 3074</p> <p>Medicaid #: 200399420A</p> <p>Surveyor: Ingrid Miller, MS, BSN, RN</p> <p>Current census: 99 skilled patients 9 home health aide only 51 Personal Service only patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 21, 2013</p>	N000000		

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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N000494	<p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on home visit observation, policy review, and interview, the agency failed to protect patient's right of dignity for 1 of 1 registered nurse (Employee A) observed at 1 of 1 home visit (#1) with a skilled nurse with the potential to affect all patients seen by this employee.</p> <p>Findings</p> <p>1. On 6/10/13 at 3:28 PM, Employee A, Registered Nurse, was observed to change a duoderm dressing on Patient #1's coccyx area. During the course of the dressing change, Employee A failed to close the window blinds or shut the door of the patient's room while the patient's</p>	N000494	<p>1.The Nursing Supervisor has inserviced the nursing staff that the patient's right of dignity must be protected. Nurses will close the window blinds and shut the door of the patient's room while performing nursing care/procedure.</p> <p>2.Competency skill to include patient dignity maintenance and will be observed during competency evaluation on a yearly or as needed basis.</p> <p>3.The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/01/2013

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	<p>buttocks and back were uncovered.</p> <p>2. On 6/11/13 at 1 PM, the director of nursing indicated the patient's door and blinds should have been closed during the wound care and when the patient's buttocks were exposed.</p> <p>3. The document titled "Policy: Patient Bill of Rights" with a review date of 1/1/13 stated, "The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p>			

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N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, document review, and interview, the agency failed to ensure treatments had been provided as ordered on the written plan of care for 4 of (2, 3, 5, 6) of 7 records reviewed of patients with skilled nursing services with the potential to affect all patients receiving skilled nursing services.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC 1/30/13) with a plan of care (POC) for the certification period of 3/30/13 - 5/29/13, failed to evidence the skilled nurse (SN) completed the oxygen saturation and weight checks as ordered on the plan of care (POC).</p> <p>a. The POC stated, "Monitor ... weight at Q [every] visit ... Monitor ... O2 [oxygen] SATs [saturation]." Nursing visits completed by Employee D on 4/3/13, 4/10/13, 4/17/13, 4/24/13, 5/1/13, 5/8/13, 5/15/13, and 5/22/13 failed to evidence the SN completed O2 Sats or weights at these visits. Employee D</p>	N000522	<p>1.The Nursing Supervisor has inserviced the nursing staff that the patient's plan of care must be implemented as ordered by MD and dated per cert. Period. O2 sats, weight checks, abdominal girth measurements, and other parameters must be performed as ordered. Nursing job description is reviewed and signed by each nurse to ensure understanding of Case Manager responsibilities.</p> <p>2.50% of all clinical records will be audited quarterly for evidence that the plan of care is implemented as ordered by MD. 100% of all plan of care with O2 sats, weights and abdominal girth measurements ordered will be audited on an ongoing basis.</p> <p>3.The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/01/2013			

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	<p>documented at each of these visits that the patient was unable to stand and failed to notify the physician that the weights and O2 Sats had not been completed.</p> <p>b. On 6/12/13 at 4:05 PM, the director of nursing indicated the weights and O2 levels were not completed as ordered on the POC and sitting and standing scales were available for SN staff to take to nursing visits.</p> <p>2. Clinical record #3, SOC 1/9/13) with a POC for the certification period of 5/11/13 - 7/8/13, failed to evidence the SN monitored weights as ordered on the POC.</p> <p>a. The POC stated, "Notify MD [medical doctor] if patient gains 5 lbs [pounds] in one week or 2 lbs in one day." Documentation for SN visits completed by Employee E, RN, on 5/13/13, 5/20/13, and 5/27/13 evidenced the patient did not have a scale in the home and the weights were not monitored. The MD was not notified that the patient's weight was not being monitored.</p> <p>b. On 6/12/13 at 4:30 PM, the director of nursing indicated the POC was not followed for this patient.</p> <p>3. Clinical record #5, SOC 9/28/12 with a</p>			

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	<p>POC for the certification period of 11/27/13 - 1/25/13, failed to evidence the SN monitored the O2 Sats as ordered on the POC.</p> <p>a. The POC stated, "O2 Sat < [less than] 89 % Notify MD" A nursing visit completed by Employee E, RN, failed to evidence a completed O2 Sat level on 1/11/13.</p> <p>b. On 6/11/13 at 12:28 PM, Employee B, director of nursing, and Employee D, RN, indicated the POC was not followed for this nurse visit.</p> <p>4. Clinical record #6, SOC 6/9/12 with a plan of care for the certification period of 4/5/13 - 6/3/12, failed to evidence the SN monitored O2 Sats, weights, and signs and symptoms of ascites, including tracking the abdominal girth.</p> <p>a. The POC stated, "SN: 1 wk [time a week] 9 [for 9 weeks] to observe / teach / perform: management and evaluation to ensure safe administration of nonskilled service ... ascites - monitor s / s [signs and symptoms] of exacerbation of ascites and effects on respiratory status ... Cardiac management: Monitor ... wt [weight]. Notify MD if O2 < 89 %." Nursing visits on 4/9/13, 4/15/13, 4/22/13, and 4/29/13 completed by Employee D, RN, failed to</p>			

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	<p>evidence O2 sat levels were monitored at any of these visits. Weights were not completed on 4/9/13 and 4/22/13. The record failed to evidence the abdominal girth had been measure at any visit by the SN.</p> <p>b. On 6/11/13 at 12:30 PM, Employee B, the director of nursing, and Employee D, RN, indicated the POC was not followed for patient #6 and the nurse did not monitor the abdominal girth and body.</p> <p>c. The agency document titled "Ascites" with no effective date stated, "Assessments 1. Daily measurement and recording of abdominal girth and body weight or as ordered by MD. 2. In a supine position, assess for the flank to bulge which indicates fluid accumulation in the peritoneal cavity. 3. Percussion for shifting dullness or detecting for fluid wave which indicates large accumulation of fluid. Nursing intervention 1. Teach about MD order / treatment 2. Nutrition - salt intake 3. Diuretics - electrolyte imbalance 4. Fluid intake 5. Care Coordination Goals 1. Daily weight loss should not exceed 1/2 lb per day 2. Maintenance of skin integrity."</p> <p>5. The agency policy titled "Skilled Nursing" with a review date of 1/1/13</p>			

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	<p>stated, "The skilled nurse is considered the case manager and as such is responsible for coordinating and / or supervising patient care to assure continuity and quality. The RN will function in accordance with the state's Nurse Practice Act and the agency policies ... Assessing the patient's present condition, including physical assessment, treatment needs, and current medications ... G. Initiating appropriate plan of care for skilled nurse intervention ... Providing direct care and / or instructing patient / family / caregiver in home care procedure per plan of treatment to assist patient in achieving jointly established goals."</p>			

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on home visit observation, clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all required elements and a timely physician signature for 3 (#1, #4, #6) of 7 clinical records reviewed with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC)</p>	N000524	<p>1.The Nursing Supervisor has inserviced nursing staff that the plan of care must include all required elements such as full side rails, ted hose and other durable medical equipments and timely dated and signed by MD.</p> <p>2.100% audit on supplies/equipment section of POT for evidence that all elements of POT is included, signed and dated timely by MD.</p> <p>3.The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure</p>	07/01/2013			

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	<p>1/14/13 with a plan of care for the certification period of 5/14/13 - 7/12/13, failed to evidence the registered nurse obtained orders for full side rails on the patient's hospital bed.</p> <p>a. On 6/10/13 at 3:28 PM, patient #1 was observed in a hospital bed that had full side rails on the right side of the bed.</p> <p>b. On 6/11/13 at 1 PM, the director of nursing indicated the registered nurse had not obtained orders for full side rails for patient #1 and that the full side rails were not on the durable medical equipment list.</p> <p>2. Clinical record #4, SOC 10/16/09 with a plan of care for the certification period of 3/29/13 - 5/27/13, failed to evidence a physician's signature until 5/7/13.</p> <p>On 6/11/13 at 11:30 AM, the director of nursing indicated the physician's signature was not signed timely.</p> <p>3. Clinical record #6, SOC 6/9/12 with a plan of care for the certification period 4/5/13 - 6/3/12, included documentation the patient wore ted hose bilaterally. The record failed to evidence the registered nurse obtained orders for the ted hose.</p> <p>A nurse visit note on 4/15/13 with a signature of Employee D, registered</p>		that this deficiency is corrected and will not recur.				

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	nurse, stated, "Use of Ted hose to reduce edema bilaterally." 4. The agency policy titled "Physician Orders" with a review date of 1/1/13 stated, "Physician's orders [Physician's Medical Plan of Treatment] should specify services, treatment, and supplies to be provided by the agency ... any continued lack of progress toward goals, unusual symptoms or reactions are to be reported to the patient physician." 60 days). The following information should be included in the plan of treatment ... Medications and treatments ... Types of services and medical supplies required ... orders for skilled nursing to include assessments, skilled intervention, instructions to patient and family ... other appropriate items."				

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N000533	<p>410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service.</p> <p>(b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure nursing plans of care included frequency and duration of visits, supervisory visits, and 60 day summaries in 2 (#8 and #9) of 2 records reviewed of patients that received home health aide only services creating the potential to affect all patients that receive home health aide only services.</p> <p>The findings include:</p>	N000533	<p>1.The Nursing Supervisor has inserviced the nursing and home health aide staff that the Agency policy and procedure on Nursing plan of care for patients receiving only home health aide services has been revised and is effective July 15, 2013 to ensure that a Registered Nurse will perform a supervisory visit every 30 days either when home health aide is present or absent to observe the care, to assess relationships and to determine whether goals are being met and to include frequency and duration of visits. 2.100% clinical record will be</p>	07/15/2013			

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	<p>1. Clinical record # 8 included "Home Health Certification and Plan of Cares" for 7/24/12 - 6/30/13. The clinical record failed to evidence any supervisory visits, any 60 day summaries, and the frequency and duration of visits on the plan of care.</p> <p>2. Clinical record #9 included "Home Health Certification and Plans of Care" for 4/6/12 - 3/31/13 and 5/1/13 - 4/30/13. The clinical record failed to evidence any supervisory visits, any 60 day summaries, and the frequency and duration of visits on the plan of care.</p> <p>3. On 6/13/13 at 3 PM, the director of nursing and administrator indicated the plans of care and clinical record did not include the 60 day summaries, supervisory visits, and frequency and duration of visits.</p> <p>4. The agency policy titled, "Nursing Plan of Care" with a review date of 1/1/13 stated, "A Registered Nurse develops a care plan for each patient admitted for Home Health Aide, Attendant care and Homemaker services only. The nursing plan of care contains the following: A plan of care and appropriate patient identifying information ... the frequency and duration of visits ... signed and dated clinical notes from all personnel providing services ... supervisory visits</p>		<p>audited to evidence that home health aide supervisory visits every 30 days were performed and that plan of care includes frequency and duration of visits.</p> <p>3.The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review, policy review, document review, and interview, the agency failed to ensure skilled nursing services were in accordance with the plan of care for 4 of (2, 3, 5, 6) of 7 records reviewed of patients with skilled nursing services with the potential to affect all patients receiving skilled nursing services.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC 1/30/13) with a plan of care (POC) for the certification period of 3/30/13 - 5/29/13, failed to evidence the skilled nurse (SN) completed the oxygen saturation and weight checks as ordered on the plan of care (POC).</p> <p>a. The POC stated, "Monitor ... weight at Q [every] visit ... Monitor ... O2 [oxygen] SATs [saturation]." Nursing visits completed by Employee D on 4/3/13, 4/10/13, 4/17/13, 4/24/13, 5/1/13, 5/8/13, 5/15/13, and 5/22/13 failed to evidence the SN completed O2 Sats or weights at these visits. Employee D documented at each of these visits that the</p>	N000537	<p>1.) The Nursing Supervisor has inserviced the nursing staff that the patient's plan of care must be implemented as ordered by MD and dated per cert. Period. O2 sats, weight checks, abdominal girth measurements, and other parameters must be performed as ordered. Nursing job description is reviewed and signed by each nurse to ensure understanding of Case Manager responsibilities.</p> <p>2.) 50% of all clinical records will be audited quarterly for evidence that the plan of care is implemented as ordered by MD. 100% of all plan of care with O2 sats, weights and abdominal girth measurements ordered will be audited on an ongoing basis.</p> <p>3.) The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/01/2013			

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	<p>patient was unable to stand and failed to notify the physician that the weights and O2 Sats had not been completed.</p> <p>b. On 6/12/13 at 4:05 PM, the director of nursing indicated the weights and O2 levels were not completed as ordered on the POC and sitting and standing scales were available for SN staff to take to nursing visits.</p> <p>2. Clinical record #3, SOC 1/9/13) with a POC for the certification period of 5/11/13 - 7/8/13, failed to evidence the SN monitored weights as ordered on the POC.</p> <p>a. The POC stated, "Notify MD [medical doctor] if patient gains 5 lbs [pounds] in one week or 2 lbs in one day." Documentation for SN visits completed by Employee E, RN, on 5/13/13, 5/20/13, and 5/27/13 evidenced the patient did not have a scale in the home and the weights were not monitored. The MD was not notified that the patient's weight was not being monitored.</p> <p>b. On 6/12/13 at 4:30 PM, the director of nursing indicated the POC was not followed for this patient.</p> <p>3. Clinical record #5, SOC 9/28/12 with a POC for the certification period of</p>						

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	<p>11/27/13 - 1/25/13, failed to evidence the SN monitored the O2 Sats as ordered on the POC.</p> <p>a. The POC stated, "O2 Sat < [less than] 89 % Notify MD" A nursing visit completed by Employee E, RN, failed to evidence a completed O2 Sat level on 1/11/13.</p> <p>b. On 6/11/13 at 12:28 PM, Employee B, director of nursing, and Employee D, RN, indicated the POC was not followed for this nurse visit.</p> <p>4. Clinical record #6, SOC 6/9/12 with a plan of care for the certification period of 4/5/13 - 6/3/12, failed to evidence the SN monitored O2 Sats, weights, and signs and symptoms of ascites, including tracking the abdominal girth.</p> <p>a. The POC stated, "SN: 1 wk [time a week] 9 [for 9 weeks] to observe / teach / perform: management and evaluation to ensure safe administration of nonskilled service ... ascites - monitor s / s [signs and symptoms] of exacerbation of ascites and effects on respiratory status ... Cardiac management: Monitor ... wt [weight]. Notify MD if O2 < 89 %." Nursing visits on 4/9/13, 4/15/13, 4/22/13, and 4/29/13 completed by Employee D, RN, failed to evidence O2 sat levels were monitored at</p>						

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	<p>any of these visits. Weights were not completed on 4/9/13 and 4/22/13. The record failed to evidence the abdominal girth had been measure at any visit by the SN.</p> <p>b. On 6/11/13 at 12:30 PM, Employee B, the director of nursing, and Employee D, RN, indicated the POC was not followed for patient #6 and the nurse did not monitor the abdominal girth and body.</p> <p>c. The agency document titled "Ascites" with no effective date stated, "Assessments 1. Daily measurement and recording of abdominal girth and body weight or as ordered by MD. 2. In a supine position, assess for the flank to bulge which indicates fluid accumulation in the peritoneal cavity. 3. Percussion for shifting dullness or detecting for fluid wave which indicates large accumulation of fluid. Nursing intervention 1. Teach about MD order / treatment 2. Nutrition - salt intake 3. Diuretics - electrolyte imbalance 4. Fluid intake 5. Care Coordination Goals 1. Daily weight loss should not exceed 1/2 lb per day 2. Maintenance of skin integrity."</p> <p>5. The agency policy titled "Skilled Nursing" with a review date of 1/1/13 stated, "The skilled nurse is considered</p>						

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	<p>the case manager and as such is responsible for coordinating and / or supervising patient care to assure continuity and quality. The RN will function in accordance with the state's Nurse Practice Act and the agency policies ... Assessing the patient's present condition, including physical assessment, treatment needs, and current medications ... G. Initiating appropriate plan of care for skilled nurse intervention ...</p> <p>Providing direct care and / or instructing patient / family / caregiver in home care procedure per plan of treatment to assist patient in achieving jointly established goals."</p>			

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N000542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on home visit observation, clinical record review, and interview, the agency failed to ensure the registered nurse had obtained all orders for the plan of care for 2 (#1, #6) of 7 records with skilled nursing with the potential to affect all of the agency's skilled nurse patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 1/14/13 with a plan of care for the certification period of 5/14/13 - 7/12/13, failed to evidence the registered nurse obtained orders for full side rails on the patient's hospital bed.</p> <p>a. On 6/10/13 at 3:28 PM, patient #1 was observed in a hospital bed that had full side rails on the right side of the bed.</p> <p>b. On 6/11/13 at 1 PM, the director of nursing indicated the registered nurse had not obtained orders for full side rails for patient #1 and that the full side rails were not on the durable medical equipment list.</p>	N000542	<p>1.The Nursing Supervisor has inserviced nursing staff that the plan of care must include all required elements such as full side rails, ted hose and other durable medical equipments and timely dated and signed by MD. 2.100% audit on supplies/equipment section of POT for evidence that all elements of POT is included, signed and dated timely by MD. 3.The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/01/2013			

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	<p>2. Clinical record #6, SOC 6/9/12 with a plan of care for the certification period 4/5/13 - 6/3/12, included documentation the patient wore ted hose bilaterally. The record failed to evidence the registered nurse obtained orders for the ted hose.</p> <p>A nurse visit note on 4/15/13 with a signature of Employee D, registered nurse, stated, "Use of Ted hose to reduce edema bilaterally."</p>			

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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure supervisory visits were made every 30 days for 2 (#8 and #9) of 2 records reviewed of patients that received home health aide only services and the agency policy was congruent with state rules creating the potential to affect all patients that receive home health aide only services.</p> <p>The findings include:</p> <p>1. Clinical record # 8 included "Home Health Certification and Plan of Cares" for 7/24/12 - 6/30/13 that identified the patient received home health aide services only. The clinical record failed to evidence any supervisory visits had been completed.</p> <p>2. Clinical record #9 included "Home Health Certification and Plan of Cares" for 4/6/12 - 3/31/13 and 5/1/13 - 4/30/13 that identified the patient received home</p>	N000606	<p>1. The Nursing Supervisor has inserviced the nursing and home health aide staff that the Agency policy and procedure on Nursing plan of care for patients receiving only home health aide services has been revised and is effective July 15, 2013 to ensure that a Registered Nurse will perform a supervisory visit every 30 days either when home health aide is present or absent to observe the care, to assess relationships and to determine whether goals are being met and to include frequency and duration of visits.</p> <p>2. 100% clinical record will be audited to evidence that home health aide supervisory visits every 30 days were performed and that plan of care includes frequency and duration of visits.</p> <p>3. The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	07/15/2013			

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	<p>health aide services only. The clinical record failed to evidence any supervisory visits had been completed.</p> <p>3. On 6/13/13 at 3 PM, the director of nursing and administrator indicated the clinical record did not evidence any supervisory visits had been completed.</p> <p>4. The agency policy titled "Nursing Plan of Care" with a review date of 1/1/13 stated, "A Registered Nurse develops a care plan for each patient admitted for Home Health Aide, Attendant care and Homemaker services only. The nursing plan of care contains the following ... supervisory visits every 60 days."</p>				