

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/14/2012
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NAME OF PROVIDER OR SUPPLIER  PEOPLEFIRST HOMECARE AND HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 DIRECTORS ROW, SUITE C INDIANAPOLIS, IN 46241
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G0000	<p>This visit was for a home health initial medicaid certification survey.</p> <p>Survey dates: 6/11-6/14/12</p> <p>Facility # 012802</p> <p>Survey Team: Dawn Snider, RN, PHNS</p> <p>Census Service Type:</p> <p>Skilled Patients: 8 Home Health Aide Only Patients: 0 Personal Service Only Patients: 0 Total: 8</p> <p>Sample:</p> <p>RR w HV: 4 RR w/o HV: 4 Total RR: 8</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN  June 18, 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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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 clinical record review, policy review, and interview the agency failed to ensure the Do Not Resuscitate Status (DNR) was ordered on the medical plan of care (#4) for 1 of 8 clinical records reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 5/14/12, included a plan of care for the certification period of 5/14/12-7/12/12 that failed to evidence a DNR order that had been signed by the physician.</p> <p>A. The physician's history and physical electronically signed on 5/10/12 states, "9. Code status is Do Not Resuscitate."</p> <p>B. The intake/referral form dated 5/14/12 evidenced "DNR : No."</p>	G0159	<p>G159 The Clinical Services Manager has inserviced the clinical staff (nursing, PT, OT, MSW, HHA) that a written DNR order must be signed by the patient's physician. The original will be placed in the patient's clinical record with a copy in the patient's home folder. All patients will be reviewed prior to sending 485 to physician for 60 days, then 20% of all clinical records will be audited quarterly for signed DNR order in chart. The Clinical Services Manager will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur</p>	06/25/2012			

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	<p>C. The admission/consent form signed by the patient on 5/14/12 evidenced "1. I have made a Living Will ... yes. ... 3. I have a Do Not Resuscitate (DNR) order ... yes."</p> <p>2. The policy dated 3/21/12 titled "DO NOT RESUSCITATE/DO NOT INTUBATE Policy No. 1-005.1" states, "A written Do Not Resuscitate (DNR) and/or Do Not Intubate (DNI) order, signed by the patient's physician (or other authorized licensed independent practitioner), must be on file in the patient's clinical record and admission folder in the patient's home."</p> <p>3. On 6/13/12 at 2:45 PM, the clinical services manager (CSM) indicated there was no DNR order.</p>						

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G0173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse included a Do Not Resuscitate (DNR) order on the plan of care for 1 of 8 patient records reviewed (#4) with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 5/14/12, included a plan of care for the certification period of 5/14/12-7/12/12 that failed to evidence a DNR order that had been signed by the physician.</p> <p>A. The physician's history and physical electronically signed on 5/10/12 states, "9. Code status is Do Not Resuscitate."</p> <p>B. The intake/referral form dated 5/14/12 evidenced "DNR : No."</p> <p>C. The admission/consent form signed by the patient on 5/14/12 evidenced "1. I have made a Living Will ... yes. ... 3. I have a Do Not Resuscitate (DNR) order ... yes."</p>	G0173	G 173 The Clinical Services Manager has inserviced the nursing staff that a written DNR order must be signed by the patient's physician. The original will be placed in the patient's clinical record with a copy in the patient's home folder. The policy titled "DO NOT RESUSCITATE/DO NOT INTUBATE, Policy No. 1-005 has been revised to state "C. The Clinical Services Manager or designee will enter a PointCare Alert into the EMR once a signed DNR order is received. This alert, stating that the patient has a DNR, must be opened prior to initiation of any visit by any discipline."All patients will be reviewed prior to sending 485 to physician for 60 days, then 20% of all clinical records will be audited quarterly for evidence of (1) signed DNR in chart; (2) generation of PointCare Alert in EMR; and (3) documentation of communication in care coordination notes between personnel and patient, family/caregiver and/or physician regarding withholding or withdrawal of life-sustaining care. The Clinical Services Manager will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will	06/25/2012			

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	<p>2. The policy dated 3/21/12 and titled "DO NOT RESUSCITATE/DO NOT INTUBATE Policy No. 1-005.1" states, "C. The DNR/DNI order will be clearly identified in the clinical record ... 1. If the patient is new to home health aide service, 'Do Not Resuscitate' will be written in the special instruction of home health aide assignment sheet."</p> <p>3. The policy dated 3/21/12 and titled "WITHHOLDING AND WITHDRAWAL OF LIFE-SUSTAINING CARE Policy No. 1-007" states, "1. Upon admission, the patient receiving life-sustaining support and his/her family/caregiver will be informed of the organization policy regarding the with holding or withdrawal of this care. 2. All communication between organization personnel and the patient and family/caregiver or the physician regarding withholding or withdrawal of life-sustaining care will be documented for the clinical record."</p> <p>4. On 6/13/12 at 2:45 PM, the clinical services manager (CSM) indicated there was no DNR order.</p>		not recur.				

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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> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record review, policy review, and interview the agency failed to ensure the Do Not Resuscitate Status (DNR) was ordered on the medical plan of care (#4) for 1 of 8 clinical records reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #4, start of care 5/14/12, included a plan of care for the</li> </ol>	N0524	N524 The Clinical Services Manager has inserviced the clinical staff (nursing, PT, OT, MSW, HHA) that a written DNR order must be signed by the patient's physician. The original will be placed in the patient's clinical record with a copy in the patient's home folder. All patients will be reviewed prior to sending 485 to physician for 60 days, then 20% of all clinical records will be audited quarterly for evidence of signed DNR in chart. The Clinical Services Manager will be	06/25/2012			

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	<p>certification period of 5/14/12-7/12/12 that failed to evidence a DNR order that had been signed by the physician.</p> <p>A. The physician's history and physical electronically signed on 5/10/12 states, "9. Code status is Do Not Resuscitate."</p> <p>B. The intake/referral form dated 5/14/12 evidenced "DNR : No."</p> <p>C. The admission/consent form signed by the patient on 5/14/12 evidenced "1. I have made a Living Will ... yes. ... 3. I have a Do Not Resuscitate (DNR) order ... yes."</p> <p>2. The policy dated 3/21/12 titled "DO NOT RESUSCITATE/DO NOT INTUBATE Policy No. 1-005.1" states, "A written Do Not Resuscitate (DNR) and/or Do Not Intubate (DNI) order, signed by the patient's physician (or other authorized licensed independent practitioner), must be on file in the patient's clinical record and admission folder in the patient's home."</p> <p>3. On 6/13/12 at 2:45 PM, the clinical services manager (CSM) indicated there was no DNR order.</p>		responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.	

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N0542	<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.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse included a Do Not Resuscitate (DNR) order on the plan of care for 1 of 8 patient records reviewed (#4) with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 5/14/12, included a plan of care for the certification period of 5/14/12-7/12/12 that failed to evidence a DNR order that had been signed by the physician.</p> <p>A. The physician's history and physical electronically signed on 5/10/12 states, "9. Code status is Do Not Resuscitate."</p> <p>B. The intake/referral form dated 5/14/12 evidenced "DNR : No."</p> <p>C. The admission/consent form signed by the patient on 5/14/12</p>	N0542	<p>N542 The Clinical Services Manager has inserviced the nursing staff that a written DNR order must be signed by the patient's physician. The original will be placed in the patient's clinical record with a copy in the patient's home folder. The policy titled "DO NOT RESUSCITATE/DO NOT INTUBATE ", Policy No. 1-005 has been revised to state "C. The Clinical Services Manager or designee will enter a PointCare Alert into the EMR once a signed DNR order is received. This alert, stating that the patient has a DNR, must be opened prior to initiation of any visit by any discipline."All patients will be reviewed prior to sending 485 to physician for 60 days, then 20% of all clinical records will be audited quarterly for evidence of: (1) signed DNR in chart; (2) generation of PointCare Alert in EMR; and (3) documentation of communication in care coordination notes between personnel and patient, family/caregiver, and/or physician regarding withholding or withdrawal of life-sustaining</p>	06/25/2012			

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	<p>evidenced "1. I have made a Living Will ... yes. ... 3. I have a Do Not Resuscitate (DNR) order ... yes."</p> <p>2. The policy dated 3/21/12 and titled "DO NOT RESUSCITATE/DO NOT INTUBATE Policy No. 1-005.1" states, "C. The DNR/DNI order will be clearly identified in the clinical record ... 1. If the patient is new to home health aide service, 'Do Not Resuscitate' will be written in the special instruction of home health aide assignment sheet."</p> <p>3. The policy dated 3/21/12 and titled "WITHHOLDING AND WITHDRAWAL OF LIFE-SUSTAINING CARE Policy No. 1-007" states, "1. Upon admission, the patient receiving life-sustaining support and his/her family/caregiver will be informed of the organization policy regarding the with holding or withdrawal of this care. 2. All communication between organization personnel and the patient and family/caregiver or the physician regarding withholding or withdrawal of life-sustaining care will be documented for the clinical record."</p> <p>4. On 6/13/12 at 2:45 PM, the clinical services manager (CSM) indicated there was no DNR order.</p>		<p>care. The Clinical Services Manager will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.</p>				

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