

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157015	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2014
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NAME OF PROVIDER OR SUPPLIER VISITING NURSE ASSOCIATION OF THE WABASH VALLEY IN	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE TERRE HAUTE, IN 47804
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G000000	<p>This was a Federal home health recertification survey.</p> <p>Survey Dates: 1/28, 1/29, 1/30, 1/31, 2/3, 2/4, and 2/6/2014</p> <p>Facility #: 005253</p> <p>Medicaid Vendor #: 100272050</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Agency Current Census: 194</p> <p>Visiting Nurse Association of the Wabash Valley is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years starting 2/12/14 due to being found out of compliance with Conditions of Participation 42 CFR 484.18 Acceptance of patients, plan of care and medical supervision, 484.30 Skilled Nursing Services, and 484.32 Therapy Services.</p> <p>The Administrator, Alternate Administrator, and Director of Clinical Services were informed of this</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>preclusion during the exit conference held at this agency on 2/6/14 at 11:30 AM.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 12, 2014</p> <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.</p> <p>Based on observation, agency policy review, and interview, the agency failed to ensure employees provided care in accordance with the agency's own infection control policies and procedures in 3 (Employees A, B, and C) of 8 home visit observations completed creating the potential to affect all of the agency's 194 current patients.</p> <p>The findings include:</p> <p>1. The agency's policy titled "Bag Technique" dated 06/2012 stated, "Hand</p>	G000121	G 121 484.12(c) COMPLIANCE WITH ACCEPTED PROFESSIONAL STANDARDS: To ensure that the HHA and its staff complies with accepted professional infection control standards and principles that apply to professionals furnishing services in an HHA, the following corrective action will occur: 1. All clinical staff will receive specific education, including didactic instruction, video, discussion and a competency skills test on proper bag technique, including use of a barrier between the bag and the home surface, and proper supply	02/27/2014

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	<p>washing supplies shall be kept in the outermost pocket of the home care bag for easy accessibility. Hands must be washed prior to entering the bag to obtain any reusable or sterile items ... The bag should not be left in the vehicle in extreme temperatures, overnight, or when the vehicle is unlocked ... after entering the patient's home, the bag shall be placed on a clean, dry surface with a barrier between the bag and the surface. Avoid cushioned surfaces such as couches ... Do not place bag on the floor ... Wash hands prior to removing any equipment or supplies from the bag ... Do not return soiled equipment to the bag. Items such as stethoscopes shall be cleaned per policy/procedure prior to returning them to the bag ... When all clean items have been returned to the proper section of the home care bag ... "</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact</p>		<p>storage on 2/26/2014 and 2/27/2014, by the Clinical Supervisor at the all staff meetings.2. All clinical staff will complete a competency quiz on the following: a. Proper hand washing prior to, during and after patient care, b. Use of proper bag barrier in the home setting, c. Proper supply storage in the bag and outside pockets, d. Disinfecting used equipment and multi-use electronic equipment, and e. proper use of personal protective equipment. 3. Anyone not attending the staff meetings scheduled for 2/26/2014 and 2/27/2014 will be expected to complete the education and quiz by 3/4/2014. 4. Starting the week of 3/4/2014, random monitoring of a maximum of 10 % (or 4) clinical staff will occur on a monthly basis by the Clinical Educator/Clinical Director or designee. 5. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. A home visit was made to patient number 1 on 01/29/14 at 09:45 AM with employee A, an Occupational Therapist (OT). The OT was observed to assess</p>			

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	<p>the patient's arm extension and flexion. The employee failed to clean the plastic measuring tool after obtaining the patients measurements.</p> <p>4. A home visit was made to patient number 2 on 01/29/14 at 10:35 PM with employee B, a Physical Therapist (PT). The employee was observed to place her bag on the patient's floor and her computer on the table without a barrier beneath the items. The PT was observed to assess and examine the patient. The employee placed the blood pressure cuff on the patient's floor prior to obtaining the blood pressure. The employee failed to clean the entire stethoscope and blood pressure cuff after obtaining the patient's blood pressure. The employee failed to clean the pulse oximeter after obtaining the patient's pulse and oxygen saturations. The employee failed to clean her hands after assessment and prior to typing on her computer.</p> <p>5. A home visit was made to patient number 3 on 01/29/14 at 1:15 PM with employee C, a Speech Therapist (ST). The employee was observed to place her bag, computer, and personal clipboard on the table without a barrier beneath the items. The employee was observed to place her blood pressure cuff and pulse oximeter on the patient's kitchen table</p>						

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G000143	<p>after patient use. The employee failed to clean her hands and the entire stethoscope, blood pressure cuff, and pulse oximeter after use.</p> <p>The employee indicated she was not able to clean her hands or equipment due to her spray bottle of cleaner was frozen from being left in her car.</p> <p>6. The above-stated observations were discussed with the Director of Nursing, Supervisor, Administrator, and Alternate Administrator on 01/31/13 at 4:30 PM. The Administrator indicated the employees had not followed standard precautions and the agency's bag technique.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure all personnel furnishing services communicated to ensure</p>	G000143	G 143 484.14(g) COORDINATION OF PATIENT SERVICES: To ensure that all staff furnishing services maintain liaison to ensure efforts are coordinated effectively and	03/04/2014	

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	<p>coordination of care while services were being provided for 6 of 16 records reviewed. (# 3, # 4, # 5, # 9, # 10, and # 12). This had the potential to affect all patients who received services with the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 3, SOC (start of care) 12/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>a. The record evidenced the patient was receiving skilled nursing and physical, occupational, and speech therapy, as well as a social worker services.</p> <p>A physical therapy note dated 01/10/14 evidenced "pts [patient's] wife had called office and office called therapist to report pt possible had a stroke/tia [transient ischemic attack] thus wants to cancel therapy today as pt not up to it." The clinical record failed to evidence notification to the skilled nurse / case manager.</p> <p>b. The Alternate Administrator and the Director of Nursing was unable to</p>		<p>support the objectives outlined in the plan of care, the following corrective action will occur: 1. Education will be provided to all clinicians on 2/25/2014 and 2/28/2014 on the correct use of the Allscripts Routine Visit template Care Management: Care/Case Coordination: "communicated with (checkbox option)." All clinicians are expected to document here the communication with the Case Manager, when a change in condition occurs. 2. In addition to this documentation, specific, detailed explanation of the conversation is to be included in the comment section of the assessment, with the status of the progress toward goals, continuation, or change in the plan of care documented. 3. Monitoring of this communication piece, including the Care Management and accompanying comment will be done by a member of the Quality Review Team member starting on the 4rd of March, 2014 and continue on an on-going basis to ensure compliance. 4. It is the responsibility of the Quality Review Team member to report audit results to the Clinical Supervisor on a weekly basis. 5. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>c. A policy titled "Therapy Services" dated 06/11, indicated "The therapist will consult and collaborate with the registered nurse who is the case manager ... "</p> <p>2. Clinical record # 4, SOC 12/13/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>3. Clinical record # 5, SOC 11/27/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>4. Clinical record # 9, SOC 12/23/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p>			

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	<p>5. Clinical record # 10, SOC 07/27/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>6. Clinical record # 12, SOC 07/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>7. The Administrator indicated the employees should had documented their communications between each other. The Alternate Administrator indicated physical therapy assistants would contact the physical therapist daily.</p> <p>8. A policy titled "Communication Sheet" dated 6/21/11 stated, "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting</p>			

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G000144	<p>weekly by the PCC ... "</p> <p>8. A policy titled "Supervision of Physical Therapy Assistant by Licensed Physical Therapist" dated 06/11 states, "The Physical Therapist will be available to, and responsible for, the direction and actions of the Physical Therapy Assistant in the performance of the direct care given by the Physical Therapy Assistant to the home care client. The Physical Therapist and the Physical Therapy Assistant consult each day a patient is seen to review all home care clients' treatments and progress toward goals ... The PTA [physical therapy assistant] will consult and document such with the supervising PT [physical therapist] at least once each day a patient is seen to review all patient treatments "</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p>	G000144	G 144 484.14(g) COORDINATION OF PATIENT	03/04/2014			

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	<p>Based on clinical record and policy review and interview, the agency failed to ensure all personnel furnishing services communicated to ensure coordination of care while services were being provided for 6 of 16 records reviewed. (# 3, # 4, # 5, # 9, # 10, and # 12). This had the potential to affect all patients who received services with the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 3, SOC (start of care) 12/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>a. The record evidenced the patient was receiving skilled nursing and physical, occupational, and speech therapy, as well as a social worker services.</p> <p>A physical therapy note dated 01/10/14 evidenced "pts [patient's] wife had called office and office called therapist to report pt possible had a stroke/tia [transient ischemic attack] thus wants to cancel therapy today as pt not up to it." The clinical record failed to evidence notification to the skilled</p>		<p>SERVICES: To ensure that the clinical record establishes that effective interchange, reporting, and coordination of patient care occurs, the following corrective action will occur: 1. Education will be provided to all clinicians on 2/25/2014 and 2/28/2014 on the correct use of the Allscripts Routine Visit template Care Management: Care/Case Coordination: "communicated with (checkbox option)." All clinicians are expected to document here the communication with the Case Manager, when a change in condition occurs. 2. In addition to this documentation, specific, detailed explanation of the conversation is to be included in the comment section of the assessment, with the status of the progress toward goals, continuation, or change in the plan of care documented. 3. Monitoring of this communication piece, including the Care Management and accompanying comment will be done by a member of the Quality Review Team member starting on the 4rd of March, 2014 and continue on an on-going basis to ensure compliance. 4. It is the responsibility of the Quality Review Team member to report audit results to the Clinical Supervisor on a weekly basis. 5. The Clinical Director will be responsible for monitoring these corrective actions to ensure that</p>		

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	<p>nurse / case manager.</p> <p>b. The Alternate Administrator and the Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>c. A policy titled "Therapy Services" dated 06/11, indicated "The therapist will consult and collaborate with the registered nurse who is the case manager ... "</p> <p>2. Clinical record # 4, SOC 12/13/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>3. Clinical record # 5, SOC 11/27/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>4. Clinical record # 9, SOC 12/23/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced</p>		this deficiency is corrected and will not recur.		

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	<p>documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>5. Clinical record # 10, SOC 07/27/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>6. Clinical record # 12, SOC 07/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>7. The Administrator indicated the employees should had documented their communications between each other. The Alternate Administrator indicated physical therapy assistants would contact the physical therapist daily.</p> <p>8. A policy titled "Communication Sheet" dated 6/21/11 stated, "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ...</p>			

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G000156	<p>The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC ... "</p> <p>8. A policy titled "Supervision of Physical Therapy Assistant by Licensed Physical Therapist" dated 06/11 states, "The Physical Therapist will be available to, and responsible for, the direction and actions of the Physical Therapy Assistant in the performance of the direct care given by the Physical Therapy Assistant to the home care client. The Physical Therapist and the Physical Therapy Assistant consult each day a patient is seen to review all home care clients' treatments and progress toward goals ... The PTA [physical therapy assistant] will consult and document such with the supervising PT [physical therapist] at least once each day a patient is seen to review all patient treatments "</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p>				

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	<p>Based on clinical record review, policy review and interview, it was determined the agency failed to ensure to ensure medications were taken as instructed and visits had been provided as ordered by the physician for 6 of 16 records reviewed (G 158), failed to ensure plans of care included all treatment orders and all medications for 3 of 4 records reviewed for patients with wound care (G 159), failed to ensure the physician was informed of a patient's change in condition, early discharges, and the need to cosigned the orders from a Nurse Practitioner creating the potential to affect all of the agency's 194 current patients (G 164), and failed to ensure verbal physician orders were put in writing, signed, and dated by the registered nurse or qualified therapist for 1 of 16 records reviewed creating the potential to affect all of the agency's 194 current patients (G 166).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the Condition of Participation 484.18: Acceptance of patients, plan of care and medical supervision.</p>	G000156	<p>G 156 484.18 ACCEPTANCE OF PATIENTS, POC, MEDICAL SUPERVISION: To ensure that the acceptance of patients, plan of care and medical supervision are done according to policy, the following corrective action plan will be implemented: 1. Education will be provided to clinical staff on the dates of 2/25/2014 and 2/28/2014 instructing the staff that orders received from Nurse Practitioners (NP) are not to be accepted unless co-signed by the attending physician overseeing the NP, prior to implementation of the orders. 2. The medical records administrative assistant, who monitors all in-coming faxes will verify that we do have a physician co-signature on any orders coming from the NP. The intake nurse will also ensure that we are obtaining the orders from the physician prior to any admission. 3. Physician orders will be monitored on an ongoing basis by the Quality Review team, who report audit results to the Clinical Supervisor. It is the responsibility of the Quality Review Team member to report audit results immediately if a discrepancy is discovered and on an on-going basis. 4. The Regulatory Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	02/28/2014			

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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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure visits had been provided as ordered by the physician for 7 (# 2, #3, # 4, # 9, # 10, # 12, and # 15) of 16 records reviewed creating the potential to affect all of the agency's 194 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 included a plan of care established by the physician for the certification period 11/21/13 to 01/19/14 that identified skilled nursing visits 1 time a week for 1 week with 2 prn (as needed) visits. A skilled nursing visit note dated 12/03/13 indicated the skilled nurse contacted the patient for a skilled nursing visit. The clinical record failed to indicate an order for the visit and the nursing note failed to indicate if the visit was a prn visit. 2. Clinical record number 3 included a plan of care established by the physician for the certification period 12/05/13 to 	G000158	G 158 484.18 ACCEPTANCE OF PATIENTS, POC, MEDICAL SUPERVISION: To ensure that the care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine, the following action plan will occur: 1. Education will be provided to clinical staff on the dates of 2/25/2014 and 2/28/2014 to reinforce agency policy that all visits made match the patient's POC. A review process will be maintained by the Quality Review Team to ensure all visits are accounted for before a final claim is billed. This review process will begin 3/3/2014. a. A patient visit calendar from Scheduler will be checked by the Quality Review Tteam against the POC to account that all visits are made. b. If missed visits are discovered, the reason for the missed visit will be documented and physician notified of the missed visit by the clinician. c. The Quality Review team member will use the Medicare Episode Tool as a final claim checklist prior to billing. 2. Education will be provided to clinical staff on the dates of 2/25/2014 and 2/28/2014 to	03/03/2014			

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	<p>02/02/14 that identified physical therapy visits were to be 1-3 visits a week for 4 weeks starting from the second week to the fifth week of home health services. The clinical record evidenced physical therapy visits had been provided 3 times a week for week number six through eight and 2 visits during week nine.</p> <p>3. Clinical record number 4 included a plan of care established by the physician for the certification period 12/13/13 to 02/10/14, that identified skilled nursing visits 1 time a week for 1 week with 2 prn (as needed visits). On 12/15/13, the skilled nursing visits were extended 1 time a week for 2 weeks. On 12/29/13, the skilled nursing visits were extended to 1 time a week for 2 weeks. The clinical record evidenced a skilled nurse visit during week six and week eight.</p> <p>a. The record also included a plan of care established by the physician for the certification period 12/23/13 to 02/20/14 with orders for physical therapy visits 3 times a week for 1 week starting on 12/24/13. On 12/29/13, physical therapy visits were extended 3 times a week for 2 weeks. On 01/12/14, physical therapy visits were extended 2 times a week for 2 weeks. The clinical record evidenced physical therapy visits had been provided 1-2 times a week for 4 weeks</p>		<p>reinforce agency policy that specific details are documented to support the need of a PRN visit. The following practices will be implemented as of the week 3/3/2014. a. PRN visits will not be entered by clinicians at the Start of Care or Recertification. b. Physician order will be obtained by clinician for a PRN visit. c. PRN visits will be requested by clinicians at the time of need and entered as a PRN visit in the "Visit Frequency" template. Use the PRN assessment template to document the visit. d. Clinicians must document specific reason for the PRN visit (e.g. Patient expresses SOB) and avoid use of generalizations (e.g. Change in Condition) e. Review of the Plan of Care/485 by the Quality Review Team will ensure that PRN visit orders are not written in advance. The Clinical Supervisor will be notified of any discrepancies. f. The Quality Review Team member will audit the PRN reason quality to ensure that the appropriate reasoning is documented. The review activity will by initiated on 3/3/2014 after education has occurred. 3. The Clinical Director will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>				

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	<p>prior to being transferred to the hospital.</p> <p>b. The Alternate Administrator and Director of Nursing indicated the patient was not seen 3 times during week three due to bad weather. Neither the Administrative Assistant nor the Director of Nursing was able to provide any further documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>4. Clinical record number 9 included a plan of care for the certification period 12/23/13-2/10/14 with orders for physical therapy 3 times a week. The record failed to evidence the patient was seen 3 times during week three.</p> <p>5. Clinical record number 10 included a plan of care established by the physician for the certification period 07/23/13 to 09/24/13 with orders for home health aide visits were to be 2 times for one week. On 08/04/13, the home health aide visits were extended 2 times a week for 8 weeks. The clinical record evidenced the home health aide visits had been provided 1 time a week during weeks four and five and no visits were made during week six.</p> <p>The Alternate Administrator and Director of Nursing was unable to</p>				

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	<p>provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>6. Clinical record number 12 included a plan of care established by the physician for the certification period 07/05/13 to 09/02/13 with orders for skilled nursing services for 2 times a week for 2 weeks with 3 prn visits and home health aide services for 2 times a week for 9 weeks. The clinical record evidenced the patient was not seen by a home health aide during week one. On 07/14/13, the skilled nurse visits were extended to 3 times for 1 week and home health aide 2 times a week for 7 weeks. The clinical record evidenced only 2 skilled nursing visits and 1 home health aide visit were made during the week of 07/14/13. On 07/22/13 the skilled nurse visits was extended to 3 times for 1 week. The clinical record evidenced 4 skilled nurse visits and 1 home health aide visit during the week of 07/22/13.</p> <p>The Director of Nursing indicated the third skilled nurse visit was supposed to be a prn visit. The Alternate Administrator and Director of Nursing were unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p>						

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	<p>7. Clinical record number 15 included a plan of care established by the physician for the certification period 06/20/13 to 08/18/13 with orders for skilled nursing services for 1 time during week one and 3 prn visits. The clinical record evidenced 2 skilled nursing visits during week one. On 07/14/13, the skilled nurse visits were extended to 1 time a week for 5 weeks. The clinical record evidenced 2 skilled nursing visits during the week of 07/15/13.</p> <p>The Director of Nursing indicated the third skilled nurse visit was supposed to be a prn visit. The Alternate Administrator and Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>8. A policy titled "Plan of Care" dated 09/03/12 stated, "The PRN orders will be accompanied by a description of the patient's needs that could warrant a visit."</p> <p>9. A policy titled "Medical Supervision" dated 09/0312, indicated "Physician will be contacted when any of the following occurs: ... Any change in patient condition or agency services, including</p>			

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G000159	<p>missed visits or non-compliance of the patient related to the Plan of Care ... "</p> <p>484.18(a) PLAN OF CARE 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 and agency policy review and interview, the agency failed to ensure plans of care included all treatment orders and all medications for 3 (# 1, # 5, and # 6) of 4 records reviewed of patients with orders for</p>	G000159	G 159 484.18(a) PLAN OF CARE: To ensure that the plan of care has been developed in consultation with the agency staff and include all treatment orders and medications, the following corrective action plan will be implemented: 1. Clinical staff will be educated on 2/25/2014	03/03/2014

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	<p>wound care creating the potential to affect all of the agency's patients with orders for wound care.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a plan of care established by the physician for the certification period 12/07/13 to 02/04/14. The record failed to evidence the plan of care had been updated to include treatment orders for wound care to the patient's coccyx. 2. Clinical record number 5 included a plan of care established by the physician for the certification period of 11/27/13 to 01/25/13. The record failed to evidence the plan of care had been updated to include treatment orders for the patient's coccyx. 3. Clinical record number 6 included a plan of care established by the physician for the certification period of 12/12/13 to 02/09/14. The clinical record failed to evidence the plan of care had been updated to include the implanted Dilaudid (pain medication) pump and the size of the huber needle for the implanted port. 4. The Alternate Administrator and the Director of Nursing were unable to 		<p>and 2/28/2014 on the need to follow, review, and update all treatment and medication orders according to the Plan of Care policy. a. Specific examples:</p> <ol style="list-style-type: none"> i. Measure any and all wounds on a weekly basis according to policy. ii. Document all medications on the Medication Profile. iii. Document the size of the Huber needle with each port access. 2. These specific education components will be taught by the Clinical Educator/Clinical Director, with auditing of these specific items to be initiated by the Quality Review Team starting 3/3/2014. Reports of any discrepancies to the Clinical Supervisor will be on-going on a weekly basis. 3. The Clinical Director is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. 				

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G000164	<p>provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>5. A policy titled "Plan of Care" dated 09/03/12, indicated "The Plan of Care shall be completed in full to include: ... Medications, treatments, and procedures, Medical supplies and equipment required ... "</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record review and interview, the agency failed to ensure the physician was informed of a patient's change in condition (# 3 and # 9), early discharges (# 10, # 11, # 15 and # 16) for 7 of 16 records reviewed, and the need to approve or cosign written prescription orders from a Nurse</p>	G000164	G164 (G163 ?) 484.18(b) PERIODIC REVIEW OF THE PLAN OF CARE: To ensure that agency professional staff promptly alerts the physician to any changes that suggest a need to alter the plan of care; the following corrective action plan will be implemented: 1. Education will be provided to the	02/28/2014

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	<p>Practitioner (# 6) creating the potential to affect all of the agency's 194 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 included a physical therapy note dated 01/10/14 that stated, "pts [patient's] wife had called office and office called therapist to report pt possible had a stroke/tia [transient ischemic attack] thus wanted to cancel therapy today as pt not up to it." The clinical record failed to evidenced the physician was notified of the patient's change in condition. 2. Clinical record number 6 included signed prescriptions by a Nurse Practitioner dated 04/05/13, 04/26/13, and 08/08/13 for 1 liter of Normal Saline Intravenous to be given 3 times a week through the patient's implanted port. The clinical record failed to evidenced the physician was notified and verified the Nurse Practitioner's order. <p>The Director of Nursing was unable to provide documentation the physician was notified prior to the administration of intravenous fluids.</p> <ol style="list-style-type: none"> 3. Clinical record number 9 included a 		<p>professional clinical staff on the dates of 2/25/2014 and 2/28/2014 on the specific items of: a. Timely notification of the physician of any change in condition b. NP orders are co-signed by attending physician prior to implementation c. Physician notification of discharge. 2. These specific education components will be done by the Clinical Educator/Clinical Director, with auditing of these specific items to be initiated by the Quality Review Team starting 3/3/2014. Reports of any discrepancies to the Clinical Supervisor will be on-going on a weekly basis to maintain compliance. 3. The Clinical Director will be responsible for monitoring these corrective actions of the timely notification of the physician of any change in condition and the physician notification of discharge to ensure that this deficiency is corrected and will not recur, starting the week of 3/3/2014. 4. The Regulatory Director will be responsible for monitoring the co-signed NP orders received by the agency to ensure that the deficiency is corrected and will not recur.</p>		

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	<p>skilled nurse visit note dated 01/06/14 that stated,"Wt [weight] gain of 8 lbs [pounds] since Saturday ... Pt states extra swelling in legs ..." The clinical record failed to evidenced the physician was notified of the patient's change in condition.</p> <p>4. Clinical record number 10 included plan of care established by the physician for the certification period 07/27/13 to 09/24/13. The clinical record evidenced a discharge oasis assessment dated 8/29/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>5. Clinical record number 11 included a plan of care established by the physician for the certification period 08/20/13 to 10/18/13. The clinical record evidenced a discharge oasis assessment dated 09/18/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>6. Clinical record number 15 included a plan of care established by the physician for the certification period 06/20/13 to 08/18/13. The clinical record evidenced a discharge oasis assessment dated 08/06/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p>			

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G000166	<p>7. Clinical record number 16 included a plan of care established by the physician for the certification period 07/02/13 to 08/30/13. The clinical record evidenced a discharge oasis assessment dated 08/06/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>8. A policy titled "Medical Supervision" dated 09/03/12 stated, "Physician will be contacted when any of the following occurs: Condition changes ... expected response to treatment ... Any change in patient condition or agency services ... "</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on clinical record review and interview, the agency failed to ensure verbal physician orders were put in writing, signed, and dated by the registered nurse or qualified therapist for 1 of 16 records reviewed creating the potential to affect all of the agency's 194</p>	G000166	G 166 484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS: To ensure that verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services, the following corrective action plan will be	02/28/2014			

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	<p>current patients. (# 3)</p> <p>The findings include:</p> <p>1. Clinical record number 3 start of care 12/05/13, included a skilled nurse visit note dated 12/16/13 that indicated Hydrocodone (pain medication) 5/325 mg was ordered for the patient. The clinical record failed to evidenced the order for Hydrocodone had been written.</p> <p>a. The record also included a physical therapy note dated 01/21/14, indicating therapy would continue 1-3 times a week. The clinical record failed to evidenced the order for continued therapy services had been written.</p> <p>b. The Alternate Administrator and Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>2. A policy titled "Physician Orders" dated 09/03/12 states, "All verbal orders must be 'read back' to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders ... When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given and then read</p>		<p>implemented: 1. The professional clinical staff will receive education on the Physician Order policy by the Clinical Educator/Clinical Director on 2/25/2014 or 2/28/2014. 2. The member of the Quality Review team responsible for over-all quality review of the episode of care is expected to review all signed orders for the POC and supplemental orders for compliance with the Physician Order policy, prior to final bill. 3. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur, starting 3/3/2014.</p>				

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G000168	<p>the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. The verbal order shall verify that the order was taken and verified by documenting this on the form and signing the form. The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature."</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record review, policy review and interview, it was determined the agency failed to ensure skilled nurse visits and assessments had been provided as ordered by the physician for 5 of 16 records reviewed creating the potential to affect all of the agency's 194 current patients (See G 170), failed to ensure the skilled nurses regularly re-evaluated the patient's nursing needs for 1 of 16 records reviewed (See G 172), failed to ensure a Registered Nurse made necessary revisions on a plan of care in relation to a pressure wound for 1 of 4 records reviewed of patients with wound care (See G 173), and failed to</p>	G000168	G168 484.30 SKILLED NURSING SERVICES: To ensure that skilled nurse visits and assessments are provided as ordered by the physician, the following action plan will be implemented: 1. The professional clinical staff will be educated by the Clinical Educator on the need for assessments of the signs/symptoms of infection and deterioration of wounds on each visit and documentation requirements of such. This will be accomplished in an education session on 3/4/2014. 2. Education with emphasis on the number of visits needing to occur according to the plan of care and change in policy on PRN visits need to be scheduled as needed	03/04/2014

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G000170	<p>ensure the physician was informed of a patient's change in condition, early discharges for 7 of 16 records reviewed, and the need to approve or cosign written prescription orders from a Nurse Practitioner creating the potential to affect all of the agency's 194 current patients (See G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.30: Skilled Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure skilled nurse visits and assessments had been provided as ordered by the</p>	G000170	<p>and the reason for the visit documented will be done on 2/25/2014 and 2/28/2014 by the Clinical Educator/Clinical Director.</p> <p>3. Documentation of wound assessments, including weekly measurements and visit frequency, will be monitored on an on-going basis by a member of the Quality Review Team and discrepancies are reported to the Clinical Supervisor. 4. The Clinical Director is responsible for over sight of these corrective actions, beginning 3/4/2014 to ensure that this deficiency is corrected and will not recur.</p> <p>G170 484.30 SKILLED NURSING SERVICES: To ensure that the agency furnishes skilled nursing services in accordance with the plans of care, the following corrective action education will be</p>	03/04/2014

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	<p>physician for 5 (#1, # 2, # 4, # 12, and # 15) of 16 records reviewed creating the potential to affect all of the agency's 194 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1, included a plan of care established by the physician for the certification period 12/07/13 to 02/04/14, that identified skill nursing to assess signs/symptoms of infection / deterioration of wounds. Skilled nursing notes dated 12/07/13, 12/10/13, 12/13/13, 12/18/13, 12/22/13, 12/29/13, and 01/13/14, failed to evidenced an assessment of the coccyx wound.</p> <p>The Alternate Administrator indicated the nurses should have assessed and measured the coccyx wound weekly.</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 11/21/13 to 01/19/14 that identified skilled nursing visits 1 time a week for 1 week with 2 prn (as needed) visits. A skilled nursing visit note dated 12/03/13 indicated the skilled nurse contacted the patient for a skilled nursing visit. The clinical record failed to indicate an order for the visit and the nursing note failed to indicate if</p>		<p>provided: 1. The professional clinical staff will be educated by the Clinical Educator/Clinical Director on 3/4/2014 on expectations for wound care/treatments, according to the plan of care. 2. Number of visits provided must match frequency and duration orders. 3. PRN visits need to be scheduled as such and the reason for the visit documented. 4. Documentation of wound assessments, including weekly measurements and visit frequency will be monitored on an on-going basis by a member of the Quality Review Team and discrepancies will be reported to the Clinical Supervisor to maintain compliance. 5. The Clinical Director will be responsible for the over sight of these corrective actions, starting on 3/4/2014, to ensure they do not recur.</p>	

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	<p>the visit was a prn visit.</p> <p>3. Clinical record number 4 included a plan of care established by the physician for the certification period 12/13/13 to 02/10/14 that identified skilled nursing visits 1 time a week for 1 week with 2 prn (as needed visits). On 12/15/13, the skilled nursing visits were extended 1 time a week for 2 weeks. On 12/29/13, the skilled nursing visits were extended to 1 time a week for 2 weeks. The clinical record evidenced a skilled nurse visit during week six and week eight.</p> <p>Neither the Administrative Assistant nor the Director of Nursing was able to provide any further documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>4. Clinical record number 12 included a plan of care established by the physician for the certification period 07/05/13 to 09/02/13 with orders for skilled nursing services for 2 times a week for 2 weeks with 3 prn visits. On 07/14/13, the skilled nurse visits were extended to 3 times for 1 week. The clinical record evidenced only 2 skilled nursing visits was made during the week of 07/14/13. On 07/22/13 the skilled nurse visits was extended to 3 times for 1 week. The clinical record evidenced 4 skilled nurse</p>						

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	<p>visits and 1 home health aide visit during the week of 07/22/13.</p> <p>The Director of Nursing indicated the third skilled nurse visit was supposed to be a prn visit. The Alternate Administrator and Director of Nursing were unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>5. Clinical record number 15 included a plan of care established by the physician for the certification period 06/20/13 to 08/18/13 with orders for skilled nursing services for 1 time during week one and 3 prn visits. The clinical record evidenced 2 skilled nursing visits during week one. On 07/14/13, the skilled nurse visits were extended to 1 time a week for 5 weeks. The clinical record evidenced 2 skilled nursing visits during the week of 07/15/13.</p> <p>The Director of Nursing indicated the third skilled nurse visit was supposed to be a prn visit. The Alternate Administrator and Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p>						

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G000172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>Based on clinical record and interview, the agency failed to ensure the skilled nurses regularly re-evaluated the patient's nursing needs for 1 of 16 records reviewed. (# 13) This had the potential to affect all patients who were receiving services from the agency.</p> <p>Findings include:</p> <p>1. Clinical record number 13 included a plan of care established by the physician for the certification period 07/06/13 to 09/02/13. A skilled nursing note dated 08/06/13 at 08:48 AM, indicated the</p>	G000172	<p>G 172 484.30 (a) DUTIES OF THE REGISTERED NURSE: To ensure that the registered nurse regularly re-evaluates the patients' nursing needs, the following corrective action plan will be implemented. 1. The education plan for 2/25/2014 and 2/28/2014 is to emphasize to staff the importance of re-evaluation and expectation of immediate follow up with all untoward clinical situations. 2. To main compliance, it is the responsibility of the Quality Review Team member to report audit results immediately if a discrepancy is discovered and on an on-going basis. 3. The Clinical Director will be</p>	03/04/2014

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G000173	<p>patient had called into the agency indicated leg discomfort and he could not wait for a nursing visit on 08/08/13. The clinical record failed to evidenced a visit was made on 08/06/13 and 08/07/13 to reevaluate the patient's needs.</p> <p>2. The Alternate Administrator and Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record and policy review and interview, the agency failed to ensure a Registered Nurse made necessary revisions on a plan of care in relation to a pressure wound for 1 of 4 records reviewed of patients with wound care. (#1) This had the potential for affect all patients receiving services from this agency.</p> <p>Findings include:</p> <p>1. Clinical record # 1 included a plan of</p>	G000173	<p>responsible for the over sight of these corrective actions, starting on 3/3/2014. 4. The particular issue raised in the record reviewed by the surveyor deals with an employee who is no longer with the agency. Disciplinary actions were taken with him prior to his leaving the agency on 9/24/2013.</p> <p>G 173 484.30(a) DUTIES OF THE REGISTERED NURSE: To ensure that the registered nurse initiates the plan of care and necessary revisions, the following correction actions will be taken:</p> <p>1. The professional clinical staff will be educated by the Clinical Educator/Clinical Director on 3/4/2014 on expectations for wound care/treatments, according to the plan of care.</p> <p>2. Documentation of wound assessments, including weekly measurements and visit frequency will be monitored on an on-going basis by a member of</p>	03/04/2014

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	<p>care established by the physician for the certification period 12/07/13 to 02/04/14 that included orders for skilled nursing to assess signs/symptoms of infection / deterioration of wounds. The Admission Comprehensive Assessment dated 12/07/13 indicated the patient had a pressure wound to the coccyx. The clinical record failed to evidenced wound care was included in the plan of care.</p> <p>The Alternate Administrator indicated the nurses wound care to the coccyx should have been included in the plan of care.</p> <p>2. A policy titled "Plan of Care" dated 09/03/12, indicated "The total Plan of Care shall be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires ... "</p>		<p>the Quality Review Team and discrepancies will be reported to the Clinical Supervisor to maintain compliance. 3. The Clinical Director will be responsible for the over sight of these corrective actions, starting on 3/4/2014 to ensure there is no recurrence of this deficiency.</p>		

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G000176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure the physician was informed of a patient's change in condition (# 3 and # 9), early discharges (# 10, # 11, # 15 and # 16) for 7 of 16 records reviewed, and the need to approve or cosign written prescription orders from a Nurse Practitioner (# 6) creating the potential to affect all of the agency's 194 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 included a physical therapy note dated 01/10/14 that stated, "pts [patient's] wife had called office and office called therapist to report pt possible had a stroke/tia [transient ischemic attack] thus wanted to cancel therapy today as pt not up to it." The clinical record failed to evidenced the physician was notified of the patient's change in condition. 2. Clinical record number 6 included signed prescriptions by a Nurse 	G000176	<p>G 176 484.30 DUTIES OF THE REGISTERED NURSE: To ensure that the registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs, the following corrective actions will be taken: 1. The policy on Medical Supervision will be reviewed with the clinical professional staff in order to emphasize the necessity of coordination of care and keeping the physician informed of changes in condition on 2/25/2014 and 2/28/2014 by the Clinical Educator/Clinical Director. 2. Documentation of physician notification of changes in condition, early discharge, and the need for approval of NP orders will be a part of the on-going audit by a member of the Quality Review team and discrepancies will be reported to the Clinical Supervisor on a weekly basis to maintain compliance. 3. The Clinical Director will be responsible for the over sight of these corrective actions, starting on 3/4/2014 to prevent recurrence.</p>	02/28/2014
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	<p>Practitioner dated 04/05/13, 04/26/13, and 08/08/13 for 1 liter of Normal Saline Intravenous to be given 3 times a week through the patient's implanted port. The clinical record failed to evidenced the physician was notified and verified the Nurse Practitioner's order.</p> <p>The Director of Nursing was unable to provide documentation the physician was notified prior to the administration of intravenous fluids.</p> <p>3. Clinical record number 9 included a skilled nurse visit note dated 01/06/14 that stated, "Wt [weight] gain of 8 lbs [pounds] since Saturday ... Pt states extra swelling in legs ..." The clinical record failed to evidenced the physician was notified of the patient's change in condition.</p> <p>4. Clinical record number 10 included plan of care established by the physician for the certification period 07/27/13 to 09/24/13. The clinical record evidenced a discharge oasis assessment dated 8/29/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>5. Clinical record number 11 included a plan of care established by the physician</p>				

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	<p>for the certification period 08/20/13 to 10/18/13. The clinical record evidenced a discharge oasis assessment dated 09/18/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>6. Clinical record number 15 included a plan of care established by the physician for the certification period 06/20/13 to 08/18/13. The clinical record evidenced a discharge oasis assessment dated 08/06/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>7. Clinical record number 16 included a plan of care established by the physician for the certification period 07/02/13 to 08/30/13. The clinical record evidenced a discharge oasis assessment dated 08/06/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>8. A policy titled "Medical Supervision" dated 09/03/12 stated, "Physician will be contacted when any of the following occurs: Condition changes ... expected response to treatment ... Any change in patient condition or agency services ... "</p>						

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G000184	<p>484.32 THERAPY SERVICES</p> <p>Based on clinical record review, policy review and interview, it was determined the agency failed to ensure the case manager was informed of a patient's change in condition for 1 of 9 clinical records reviewed of patients receiving therapy services creating the potential to affect all of the agency's patients that receive therapy services (G 188) and failed to ensure all the physical therapist supervised the physical therapy assistant for 6 of 9 records reviewed of patients receiving therapy services with the potential to affect all patients who received therapy services with the agency (G 190).</p> <p>The cumulative effect of these systemic problems resulted in the inability to meet the Condition of Participation 484.32: Therapy Services.</p>	G000184	<p>G 184 484.32 THERAPY SERVICES: To ensure that the case manager is informed of a patient's change in condition, the following corrective action measures will be implemented:</p> <p>1. All professional clinical staff will be educated on the need to communicate any change in condition with the case manager and the physician, including review of policies Care Coordination and Therapy Services on 2/25/2014 and 2/28/2014 by the Clinical Educator/Clinical Director. 2. Care Management: Care/Case Coordination documentation will be monitored on an on-going basis by a member of the Quality Review team and discrepancies will be reported to the Clinical Director on a weekly basis to maintain compliance. 3. The Clinical Director will be responsible for the over sight of these corrective actions, starting on 3/4/2014 to ensure that the deficiency has been corrected and will not recur.</p>	02/28/2014

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G000188	<p>484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the case manager was informed of a patient's change in condition (# 3) for 1 of 9 clinical records reviewed of patients receiving therapy services creating the potential to affect all of the agency's patients that receive therapy services.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a physical therapy note dated 01/10/14 at 10:45 AM that stated, "pts [patient] wife had called office and office called therapist to report pt possibly had a stroke/tia [transient ischemic attack] thus wanted to cancel therapy today as pt not up to it." The clinical record failed to evidenced the case manager was notified of the patient's change in condition.</p> <p>The Alternate Administrator and the Director of Nursing were unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p>	G000188	G188 484.32 THERAPY SERVICES: To ensure that the qualified therapist advises and consults with the family and other agency personnel, the following corrective action measures will be implemented: 1. Education will be provided to all clinicians on 2/25/2014 and 2/28/2014 on the correct use of the Allscripts Routine Visit template Care Management: Care/Case Coordination: "communicated with (checkbox option)." Emphasis is on the PTA use of this to communicate with the PT on a per visit basis. The therapist is expected to document here the communication with the Case Manager, when a change in condition occurs. 2. In addition to this documentation, specific, detailed explanation of the conversation is to be included in the comment section of the assessment, with the status of the progress toward goals, continuation, or change in the plan of care documented. 3. Monitoring of this communication piece, including the Care Management and accompanying comment will be done by a member of the Quality Review Team member starting on the 4rd of March, 2014 and continue on an on-going basis to ensure compliance. 1. It is the	02/28/2014			

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G000190	<p>2. A policy titled "Therapy Services" dated 06/11, indicated "The therapist will consult and collaborate with the registered nurse who is the case manager ..."</p> <p>484.32(a) SUPERVISION OF PHYSICAL & OCCUPATIONAL Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapy assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure all the physical therapist supervised the physical therapy assistant for 6 of 9 records reviewed of patients receiving therapy services. (# 3, # 4, # 5, # 9, # 10, and # 12). This had the potential to affect all patients who received therapy services with the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 3, SOC (start of</p>	G000190	<p>responsibility of the Quality Review Team member to report audit results to the Clinical Director on a weekly basis to maintain compliance. 2. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>G 190 484.32(a) SUPERVISION OF PHYSICAL & OCCUPATIONAL: To ensure that services furnished by a qualified therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist and that those services are planned, delegated and supervised by the therapists, the following corrective actions will be taken: 1. All professional clinical staff will be educated on the need to communicate patient status between the PTA and PT and with the case manager and</p>	02/28/2014

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	<p>care) 12/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>2. Clinical record # 4, SOC 12/13/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>3. Clinical record # 5, SOC 11/27/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>4. Clinical record # 9, SOC 12/23/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>5. Clinical record # 10, SOC 07/27/13, evidenced the patient was receiving physical therapy services. The clinical</p>		<p>the physician, including review of policies Care Coordination, Therapy Services, and Supervision of Therapy Assistants on 2/25/2014 and 2/28/2014 by the Clinical Educator/Clinical Director. 2. Monitoring of this communication piece, including the Care Management and accompanying comment will be done by a member of the Quality Review Team member starting on the 4rd of March, 2014, and continue on an on-going basis to ensure compliance. 3. It is the responsibility of the Quality Review Team member to report audit results of documentation discrepancies to the Clinical Director on a weekly basis. 4. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>6. Clinical record # 12, SOC 07/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>The Administrator indicated the employees should had documented their communications between each other. The Alternate Administrator indicated physical therapy assistants would contact the physical therapist daily.</p> <p>7. A policy titled "Communication Sheet" dated 6/21/11, indicated "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC ... "</p> <p>8. A policy titled "Supervision of</p>			

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G000225	<p>Physical Therapy Assistant by Licensed Physical Therapist" dated 06/11, indicated "The Physical Therapist will be available to, and responsible for, the direction and actions of the Physical Therapy Assistant in the performance of the direct care given by the Physical Therapy Assistant to the home care client. The Physical Therapist and the Physical Therapy Assistant consult each day a patient is seen to review all home care clients' treatments and progress toward goals ... The PTA (physical therapy assistant) will consult and document such with the supervising PT (physical therapist) at least once each day a patient is seen to review all patient treatments "</p> <p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure visits were made as ordered and only as ordered for 2 of 6 clinical</p>	G000225	G 225 484.36 (c (2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE: To ensure that the home health aide provides services that are ordered by the physician in the plan of care and that the aide is	02/28/2014

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	<p>records reviewed of patients that received home health aide services (#10 and #12) with the potential to affect all the agency's patients that receive home health aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 10 included a plan of care established by the physician for the certification period 07/23/13 to 09/24/13 with orders for home health aide visits were to be 2 times for one week. On 08/04/13, the home health aide visits were extended 2 times a week for 8 weeks. The clinical record evidenced the home health aide visits had been provided 1 time a week during weeks four and five and no visits were made during week six. 2. Clinical record number 12 included a plan of care established by the physician for the certification period 07/05/13 to 09/02/13 with orders for home health aide services for 2 times a week for 9 weeks. The clinical record evidenced the patient was not seen by a home health aide during week one and only 1 home health aide visit was made during the weeks of 07/14/13 and 07/22/13. 3. The Administrative Assistant and Director of Nursing was unable to 		<p>permitted to perform under state law, the following corrective actions will be taken: 1. Education to the clinical staff will focus on the need to include on the scheduler component of the software, a note to explain why a visit was missed. Education sessions will occur on 2/25/2014, 2/26/2014, 2/27/2014 and 2/28/2014 and will be led by the Clinical Educator/Clinical Director. 2. Education will focus on the home health aide responsibility to inform the Home Health Aide Supervisor and the case manager of the missed visit and the reason for the missed visit. It is the responsibility of Home Health Aide Supervisor or designee to notify the attending physician of the missed visit. 3. This documentation will be monitored by a joint effort between the Home Health Aide Supervisor and the Billing Specialist who does the verification of visit checks, starting 3/4/2014. Any discrepancy is reported to the Home Health Supervisor or the Clinical Director to maintain compliance. 4. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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G000236	<p>provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>4. A policy titled "Medical Supervision" dated 09/0312, indicated "Physician will be contacted when any of the following occurs: ... Any change in patient condition or agency services, including missed visits or non-compliance of the patient related to the Plan of Care ... "</p> <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 skilled nurses documented how wound care / treatment was provided for 3 of 4 patient's reviewed who had treatment orders. This had the potential to affect all patients with treatment orders who</p>	G000236	G 236 484.48 CLINICAL RECORDS: To ensure that the clinical record contains pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services, the follow actions will be taken:	03/04/2014

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	<p>currently receive services from the agency. (#5, # 15, and #16).</p> <p>Findings include:</p> <p>1. Clinical record number 5 included a plan of care established by the physician for the certification period 11/27/13 to 01/25/14. The clinical record identified skilled nurses provided wound care on 11/27/13, 12/03/13, 12/06/13, 12/09/13, 12/13/13, 12/17/13, 01/01/14, 01/08/14, 01/21/14, 01/22/14, and 01/24/14. The clinical record failed to evidenced written documentation on how wound care was provided by the skilled nurse.</p> <p>2. Clinical record number 15 included a plan of care established by the physician for the certification period 06/20/13 to 08/18/13. The clinical record identified skilled nurses provided wound care on 06/20/13, 06/22/13, 06/25/13, 06/28/13, 07/01/13, 07/05/13, 07/08/13, 07/12/13, 07/16/13, 07/18/13, 07/23/13, and 07/26/13. The clinical record failed to evidenced written documentation on how wound care was provided by the skilled nurse.</p> <p>3. Clinical record number 16 included a plan of care established by the physician for the certification period 07/02/13 to 08/30/13. The clinical record identified</p>		<p>1. The professional nursing staff will review the expectations of wound care/ treatments documentation during this education to be provided on 3/4/2014 by the Clinical Educator/Clinical Director. 2. Wound care/treatments intervention documentation is to be monitored on an on-going basis by a member of the Quality Review Team and discrepancies are reported to the Clinical Supervisor to maintain compliance. 3. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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G000331	<p>skilled nurses provided wound care on 07/02/13, 07/05/13, 07/08/13, 07/10/13, 07/12/13, 07/15/13, 07/17/13, 07/18/13, 07/19/13, 07/24/13, 07/31/13, and 08/02/13. The clinical record failed to evidenced written documentation on how wound care was provided by the skilled nurse.</p> <p>4. The Alternate Administrator and Director of Nursing were unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the coccyx wound was assessed and measured upon admission (# 1) and failed to accurately assess and determine the immediate care and support needs (# 7) for 2 of 16 clinical records reviewed. This had the potential to affect all current 194 patients</p>	G000331	G 331 484.55(a) INITIAL ASSESSMENT VISIT: To ensure that a registered nurse conducts an initial assessment visit to determine the immediate care and support needs of the patient and to determine (for Medicare patients) the eligibility for the Medicare home benefit, including homebound status, the following corrective actions will be taken: 1. The expectations of following the Comprehensive	02/28/2014

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	<p>admitted to the agency.</p> <p>Findings include:</p> <p>1. Clinical record number 1, start of care 12/7/13, included a plan of care established by the physician for the certification period 12/07/13 to 02/04/14 that included orders for skilled nursing to assess signs/symptoms of infection / deterioration of wounds. Skilled nursing notes dated 12/07/13, 12/10/13, 12/13/13, 12/18/13, 12/22/13, 12/29/13, and 01/13/14, failed to evidenced an assessment and / or measurements of the coccyx wound.</p> <p>The Alternate Administrator indicated the nurses should have assessed and measured the coccyx wound upon admission.</p> <p>2. Clinical record number 7, start of care 1/21/14, included a plan of care established by the physician for the certification period of 01/21/14 to 03/21/14 that included a primary diagnosis of diabetes mellitus type 2 - uncontrolled. Other pertinent diagnoses included gastroparesis, coronary arteriosclerosis unspecified, congestive heart failure, muscle weakness, hypertension, personal history of fall, cardiac pacemaker, and aorta-coronary</p>		<p>Assessment Policy will be reviewed with the professional clinical staff on 2/25/2014 and 2/28/2014, with emphasis on responsiveness to immediate care needs. 2. To maintain compliance with this standard, every patient's record will be reviewed for the Comprehensive Assessment by members of the Quality Review team. Any discovered discrepancies will be reported to the clinician and the Clinical Supervisor. 3. Starting 3/3/2014, the Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>bypass. The comprehensive assessment dated 1/21/14 failed to accurately determine the immediate care and support needs of the patient's plan of care.</p> <p>a. The clinical record included a hospital history and physical note dated of 01/16/14 indicating the patient had persistent nausea since the implantation of a pacemaker and a recent hospitalization for a syncopal event with a laceration to the patient's scalp.</p> <p>b. a. The clinical record included a consultation note dated 01/18/14 indicating the patient had dysphagia due to esophageal spasm and responds well with nitroglycerin.</p> <p>c. During a home visit on 1/30/14 at 1:15 PM, the patient indicated she had used the nitroglycerin for difficulty swallowing.</p> <p>d. The clinical record included a hospital discharge summary dated 01/20/14 indicating the patient's persistent nausea and vomiting was "secondary to gastroparesis secondary to her diabetes mellitus (improved) ... hyponatremia secondary to the above (resolved) ... Non-insulin dependent diabetes mellitus (stable). The "Hospital</p>				

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	<p>Course" indicated the patient's Lasix and Aldactone (water pills) was increased due to signs of fluid retention (improved).</p> <p>3. A policy titled "Comprehensive Patient Assessment" [undated], indicated "A thorough, well-organized, comprehensive and accurate assessment, consistent with the patient's immediate needs will be completed for all patients ... The assessment identifies facilitating factors and possible barriers to patient reaching his or her goals including presenting problems ... The Comprehensive Assessment will include a review of all medications the patient is using. This assessment will identify potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with therapy ... Reassessments are conducted based on patient needs, physician orders, professional judgment ... "</p>			

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G000337	<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 and policy review and interview, the agency failed to include medications and update the medication profile for 3 (# 3, # 5, # 6) of 16 records reviewed. This had the potential to affect all 194 patients who currently receive home health services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3, SOC (start of care) 12/05/13, included a skilled nursing note dated 12/16/13 that indicated Hydrocodone (pain medication) 5/325 mg was ordered for the patient. The clinical record failed to evidenced the medication profile had been updated. 2. Clinical record number 5, SOC 11/27/13, included a skilled nursing note dated 12/03/13 that indicated the physician office had called in an order for Ultram for the patient. The clinical record failed to evidenced the medication profile had been updated. 	G000337	<p>G 337 484.55(c) DRUG REGIMEN REVIEW: To ensure that the comprehensive assessment includes a review of all meds the patient is currently taking 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 non compliance with drug therapy, the following corrective action plans will occur:</p> <ol style="list-style-type: none"> 1. On date 2/25/2014 and 2/28/2014, clinical staff will be educated by a Quality Review Nurse, on the expectation that all medications must in included on the Medication Profile, including any revisions or additions that occur during the episode. 2. The Quality Review audit tool is used to check for all new and revised medications on the Medication Profile to maintain compliance. 1. The Clinical Review team will report findings to the Clinical Supervisor upon any occurrence of inadequate documentation of meds. Follow up consultation between the staff 	02/28/2014

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	<p>3. Clinical record number 6 included a plan of care established by the physician for the certifying period of 12/12/13 to 02/09/14. The clinical record failed to evidence the plan of care had been updated to include the implanted Dilaudid (pain medication) pump.</p> <p>4. A policy titled "Comprehensive Patient Assessment" [undated], indicated "A thorough, well-organized, comprehensive and accurate assessment, consistent with the patient's immediate needs will be completed for all patients ... The assessment identifies facilitating factors and possible barriers to patient reaching his or her goals including presenting problems ... The Comprehensive Assessment will include a review of all medications the patient is using. This assessment will identify potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with therapy ... Reassessments are conducted based on patient needs, physician orders, professional judgment ... "</p>		<p>member and with the Clinical Supervisor will occur. 2. Starting 3/3/2014, the Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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N000000	This was a State home health re-licensure survey. Survey Dates: 1/28, 1/29, 1/30, 1/31, 2/3, 2/4, and 2/6/2014 Facility #: 005253 Medicaid Vendor #: 100272050 Surveyor: Shannon Pietraszewski, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN February 12, 2014	N000000		
N000470	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. Based on observation, agency policy review, and interview, the agency failed to ensure employees provided care in accordance with the agency's own infection control policies and procedures in 3 (Employees A, B, and C) of 8 home visit observations completed creating the potential to affect all of the agency's 194 current patients.	N000470	N470 410 IAC 17-12-1(m) Home health agency administration/management: To ensure that policies and procedures related to the control of communicable diseases are abided by in the clinical setting by all clinicians. 1. All clinical staff will receive specific education, including didactic instruction, video, discussion and a	03/04/2014

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	<p>The findings include:</p> <p>1. The agency's policy titled "Bag Technique" dated 06/2012 stated, "Hand washing supplies shall be kept in the outermost pocket of the home care bag for easy accessibility. Hands must be washed prior to entering the bag to obtain any reusable or sterile items ... The bag should not be left in the vehicle in extreme temperatures, overnight, or when the vehicle is unlocked ... after entering the patient's home, the bag shall be placed on a clean, dry surface with a barrier between the bag and the surface. Avoid cushioned surfaces such as couches ... Do not place bag on the floor ... Wash hands prior to removing any equipment or supplies from the bag ... Do not return soiled equipment to the bag. Items such as stethoscopes shall be cleaned per policy/procedure prior to returning them to the bag ... When all clean items have been returned to the proper section of the home care bag ... "</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both</p>		<p>competency skills test on proper bag technique, including use of a barrier between the bag and the home surface, and proper supply storage on 2/26/2014 and 2/27/2014, by the Clinical Supervisor at the all staff meetings. 2. All clinical staff will complete a competency quiz on the following: a. Proper hand washing prior to, during and after patient care, b. use of proper bag barrier in the home setting, c. proper supply storage in the bag and outside pockets, d. disinfecting used equipment and multi-use electronic equipment, and e. proper use of personal protective equipment. 3. Anyone not attending the staff meetings scheduled for 2/26/2014 and 2/27/2014 will be expected to complete the education and quiz by 3/4/2014. 4. Starting the week of 3/3/2014, random monitoring of a maximum of 4 clinical staff will occur on a monthly basis by the Clinical Educator/Clinical Director or designee. 5. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.			

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	<p>3. A home visit was made to patient number 1 on 01/29/14 at 09:45 AM with employee A, an Occupational Therapist (OT). The OT was observed to assess the patient's arm extension and flexion. The employee failed to clean the plastic measuring tool after obtaining the patients measurements.</p> <p>4. A home visit was made to patient number 2 on 01/29/14 at 10:35 PM with employee B, a Physical Therapist (PT). The employee was observed to place her bag on the patient's floor and her computer on the table without a barrier beneath the items. The PT was observed to assess and examine the patient. The employee placed the blood pressure cuff on the patient's floor prior to obtaining the blood pressure. The employee failed to clean the entire stethoscope and blood pressure cuff after obtaining the patient's blood pressure. The employee failed to clean the pulse oximeter after obtaining the patient's pulse and oxygen saturations. The employee failed to clean her hands after assessment and prior to typing on her computer.</p> <p>5. A home visit was made to patient number 3 on 01/29/14 at 1:15 PM with employee C, a Speech Therapist (ST). The employee was observed to place her</p>			

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N000484	<p>bag, computer, and personal clipboard on the table without a barrier beneath the items. The employee was observed to place her blood pressure cuff and pulse oximeter on the patient's kitchen table after patient use. The employee failed to clean her hands and the entire stethoscope, blood pressure cuff, and pulse oximeter after use.</p> <p>The employee indicated she was not able to clean her hands or equipment due to her spray bottle of cleaner was frozen from being left in her car.</p> <p>6. The above-stated observations were discussed with the Director of Nursing, Supervisor, Administrator, and Alternate Administrator on 01/31/13 at 4:30 PM. The Administrator indicated the employees had not followed standard precautions and the agency's bag technique.</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record and policy review and interview, the agency failed</p>	N000484	N 484 410 IAC 17-12-2(g) QA and performance improvement: To ensure that all personnel	02/28/2014			

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	<p>to ensure all personnel furnishing services communicated to ensure coordination of care while services were being provided for 6 of 16 records reviewed. (# 3, # 4, # 5, # 9, # 10, and # 12). This had the potential to affect all patients who received services with the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 3, SOC (start of care) 12/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>a. The record evidenced the patient was receiving skilled nursing and physical, occupational, and speech therapy, as well as a social worker services.</p> <p>A physical therapy note dated 01/10/14 evidenced "pts [patient's] wife had called office and office called therapist to report pt possible had a stroke/tia [transient ischemic attack] thus wants to cancel therapy today as pt not up to it." The clinical record failed to evidence notification to the skilled nurse / case manager.</p>		<p>providing services are maintaining effective communications to ensure that efforts appropriately complement one another and support the objectives of the patient care the following action items have been taken: 1. Education will be provided to all clinicians on 2/25/2014 and 2/28/2014 on the correct use of the Allscripts Routine Visit template Care Management: Care/Case Coordination: "communicated with (checkbox option)." All clinicians are expected to document here the communication with the Case Manager, when a change in condition occurs. 2. In addition to this documentation, specific, detailed explanation of the conversation is to be included in the comment section of the assessment, with the status of the progress toward goals, continuation, or change in the plan of care documented. 3. Monitoring of this communication piece, including the Care Management and accompanying comment will be done by a member of the Quality Review Team member starting on the 4rd of March, 2014 and continue on an on-going basis to ensure compliance. 4. It is the responsibility of the Quality Review Team member to report audit results to the Clinical Supervisor on a weekly basis to maintain compliance. 5. The</p>				

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	<p>b. The Alternate Administrator and the Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>c. A policy titled "Therapy Services" dated 06/11, indicated "The therapist will consult and collaborate with the registered nurse who is the case manager ... "</p> <p>2. Clinical record # 4, SOC 12/13/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>3. Clinical record # 5, SOC 11/27/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>4. Clinical record # 9, SOC 12/23/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the</p>		Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

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	<p>physical therapist assistant.</p> <p>5. Clinical record # 10, SOC 07/27/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>6. Clinical record # 12, SOC 07/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>7. The Administrator indicated the employees should had documented their communications between each other. The Alternate Administrator indicated physical therapy assistants would contact the physical therapist daily.</p> <p>8. A policy titled "Communication Sheet" dated 6/21/11 stated, "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator</p>						

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N000522	<p>(PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC ... "</p> <p>8. A policy titled "Supervision of Physical Therapy Assistant by Licensed Physical Therapist" dated 06/11 states, "The Physical Therapist will be available to, and responsible for, the direction and actions of the Physical Therapy Assistant in the performance of the direct care given by the Physical Therapy Assistant to the home care client. The Physical Therapist and the Physical Therapy Assistant consult each day a patient is seen to review all home care clients' treatments and progress toward goals ... The PTA [physical therapy assistant] will consult and document such with the supervising PT [physical therapist] at least once each day a patient is seen to review all patient treatments "</p> <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 and agency policy review and interview, the agency failed to ensure visits had been provided</p>	N000522	N522 410 IAC 17-13-1(a) Patient Care : To ensure that the medical care follows a written	02/28/2014

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	<p>as ordered by the physician for 7 (# 2, #3, # 4, # 9, # 10, # 12, and # 15) of 16 records reviewed creating the potential to affect all of the agency's 194 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 included a plan of care established by the physician for the certification period 11/21/13 to 01/19/14 that identified skilled nursing visits 1 time a week for 1 week with 2 prn (as needed) visits. A skilled nursing visit note dated 12/03/13 indicated the skilled nurse contacted the patient for a skilled nursing visit. The clinical record failed to indicate an order for the visit and the nursing note failed to indicate if the visit was a prn visit. 2. Clinical record number 3 included a plan of care established by the physician for the certification period 12/05/13 to 02/02/14 that identified physical therapy visits were to be 1-3 visits a week for 4 weeks starting from the second week to the fifth week of home health services. The clinical record evidenced physical therapy visits had been provided 3 times a week for week number six through eight and 2 visits during week nine. 3. Clinical record number 4 included a 		<p>medical plan of care established and periodically reviewed by the physician, the following action plans will be initiated: 1. Education will be provided to clinical staff on the dates of 2/25/2014 and 2/28/2014 to reinforce agency policy that all visit made match the patient's POC. A review process will be maintained by the Review team to ensure all visits are accounted for before a final claim is billed. This review process will begin 3/3/2014. a. A patient visit calendar from Scheduler will be checked by the Quality Review Team against the POC to account that all visits are made. b. If missed visits are discovered, the reason for the missed visit will be documented and physician notified of the missed visit by the clinician. 2. The Quality Review team member will use the Medicare Episode Tool as a final claim checklist prior to billing to maintain compliance. 3. The Clinical Director will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>plan of care established by the physician for the certification period 12/13/13 to 02/10/14, that identified skilled nursing visits 1 time a week for 1 week with 2 prn (as needed visits). On 12/15/13, the skilled nursing visits were extended 1 time a week for 2 weeks. On 12/29/13, the skilled nursing visits were extended to 1 time a week for 2 weeks. The clinical record evidenced a skilled nurse visit during week six and week eight.</p> <p>a. The record also included a plan of care established by the physician for the certification period 12/23/13 to 02/20/14 with orders for physical therapy visits 3 times a week for 1 week starting on 12/24/13. On 12/29/13, physical therapy visits were extended 3 times a week for 2 weeks. On 01/12/14, physical therapy visits were extended 2 times a week for 2 weeks. The clinical record evidenced physical therapy visits had been provided 1-2 times a week for 4 weeks prior to being transferred to the hospital.</p> <p>b. The Alternate Administrator and Director of Nursing indicated the patient was not seen 3 times during week three due to bad weather. Neither the Administrative Assistant nor the Director of Nursing was able to provide any further documentation and/or information when asked on 02/04/14 at</p>			

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	<p>1:30 PM.</p> <p>4. Clinical record number 9 included a plan of care for the certification period 12/23/13-2/10/14 with orders for physical therapy 3 times a week. The record failed to evidence the patient was seen 3 times during week three.</p> <p>5. Clinical record number 10 included a plan of care established by the physician for the certification period 07/23/13 to 09/24/13 with orders for home health aide visits were to be 2 times for one week. On 08/04/13, the home health aide visits were extended 2 times a week for 8 weeks. The clinical record evidenced the home health aide visits had been provided 1 time a week during weeks four and five and no visits were made during week six.</p> <p>The Alternate Administrator and Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>6. Clinical record number 12 included a plan of care established by the physician for the certification period 07/05/13 to 09/02/13 with orders for skilled nursing services for 2 times a week for 2 weeks with 3 prn visits and home health aide</p>			

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	<p>services for 2 times a week for 9 weeks. The clinical record evidenced the patient was not seen by a home health aide during week one. On 07/14/13, the skilled nurse visits were extended to 3 times for 1 week and home health aide 2 times a week for 7 weeks. The clinical record evidenced only 2 skilled nursing visits and 1 home health aide visit were made during the week of 07/14/13. On 07/22/13 the skilled nurse visits was extended to 3 times for 1 week. The clinical record evidenced 4 skilled nurse visits and 1 home health aide visit during the week of 07/22/13.</p> <p>The Director of Nursing indicated the third skilled nurse visit was supposed to be a prn visit. The Alternate Administrator and Director of Nursing were unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>7. Clinical record number 15 included a plan of care established by the physician for the certification period 06/20/13 to 08/18/13 with orders for skilled nursing services for 1 time during week one and 3 prn visits. The clinical record evidenced 2 skilled nursing visits during week one. On 07/14/13, the skilled nurse visits were extended to 1 time a</p>				

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	<p>week for 5 weeks. The clinical record evidenced 2 skilled nursing visits during the week of 07/15/13.</p> <p>The Director of Nursing indicated the third skilled nurse visit was supposed to be a prn visit. The Alternate Administrator and Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>8. A policy titled "Plan of Care" dated 09/03/12 stated, "The PRN orders will be accompanied by a description of the patient's needs that could warrant a visit."</p> <p>9. A policy titled "Medical Supervision" dated 09/0312, indicated "Physician will be contacted when any of the following occurs: ... Any change in patient condition or agency services, including missed visits or non-compliance of the patient related to the Plan of Care ... "</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 clinical record and agency policy review and interview, the agency failed to ensure plans of care included all treatment orders and all medications for 3 (# 1, # 5, and # 6) of 4 records reviewed of patients with orders for wound care creating the potential to affect all of the agency's patients with orders for wound care.</p> <p>The findings include:</p>	N000524	<p>N524 410 IAC 17-13-1(a)(1) Patient Care: To ensure that the medical plan of care includes all treatment orders and all medications, the following corrective action steps have been taken: 1. Clinical staff will be educated on 2/25/2014 and 2/28/2014 on the need to follow, review, and update all treatment and medication orders according to the Plan of Care policy. a. Specific examples:</p> <ul style="list-style-type: none"> i. <p>Measure any and all wounds on</p>	02/28/2014

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	<p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 12/07/13 to 02/04/14. The record failed to evidence the plan of care had been updated to include treatment orders for wound care to the patient's coccyx.</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period of 11/27/13 to 01/25/13. The record failed to evidence the plan of care had been updated to include treatment orders for the patient's coccyx.</p> <p>3. Clinical record number 6 included a plan of care established by the physician for the certification period of 12/12/13 to 02/09/14. The clinical record failed to evidence the plan of care had been updated to include the implanted Dilaudid (pain medication) pump and the size of the huber needle for the implanted port.</p> <p>4. The Alternate Administrator and the Director of Nursing were unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>5. A policy titled "Plan of Care" dated 09/03/12, indicated "The Plan of Care</p>		<p>a weekly basis according to policy.</p> <p>ii. Document all medications on the Medication Profile.</p> <p>iii. Document the size of the Huber needle with each port access.</p> <p>2. These specific education components will be taught by the Clinical Educator/Clinical Director, with auditing of these specific items to be initiated by the Quality Review Team starting 3/4/2014. Reports of any discrepancies to the Clinical Supervisor will be on-going on a weekly basis to maintain compliance. 3. The Clinical Director is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>				

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N000537	<p>shall be completed in full to include: ... Medications, treatments, and procedures, Medical supplies and equipment required ... "</p> <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 and interview, the agency failed to ensure skilled nurse visits and assessments had been provided as ordered by the physician for 5 (#1, # 2, # 4, # 12, and # 15) of 16 records reviewed creating the potential to affect all of the agency's 194 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1, included a plan of care established by the physician for the certification period 12/07/13 to 02/04/14, that identified skill nursing to assess signs/symptoms of infection / deterioration of wounds. Skilled nursing notes dated 12/07/13, 12/10/13, 12/13/13, 12/18/13, 12/22/13, 12/29/13, and 01/13/14, failed to evidenced an assessment of the coccyx wound.</p> <p>The Alternate Administrator indicated the nurses should have</p>	N000537	<p>N537 410 IAC 17-14-1(a) Scope of Services: To ensure that the home health agency provides nursing services by a registered nurse or licensed practical nurse in accordance with the medical plan of care, the following action steps will be taken: 1. Clinical staff will be educated on 2/25/2014 and 2/28/2014 on the need to follow, review, and update all treatment and medication orders according to the Plan of Care policy. a. Specific examples:</p> <p>i. Measure any and all wounds on a weekly basis according to policy.</p> <p>ii. Document all medications on the Medication Profile.</p> <p>iii. Document the size of the Huber needle with each port access. 2. These specific education components will be taught by the Clinical Educator/Clinical Director, with</p>	02/28/2014

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	<p>assessed and measured the coccyx wound weekly.</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 11/21/13 to 01/19/14 that identified skilled nursing visits 1 time a week for 1 week with 2 prn (as needed) visits. A skilled nursing visit note dated 12/03/13 indicated the skilled nurse contacted the patient for a skilled nursing visit. The clinical record failed to indicate an order for the visit and the nursing note failed to indicate if the visit was a prn visit.</p> <p>3. Clinical record number 4 included a plan of care established by the physician for the certification period 12/13/13 to 02/10/14 that identified skilled nursing visits 1 time a week for 1 week with 2 prn (as needed visits). On 12/15/13, the skilled nursing visits were extended 1 time a week for 2 weeks. On 12/29/13, the skilled nursing visits were extended to 1 time a week for 2 weeks. The clinical record evidenced a skilled nurse visit during week six and week eight.</p> <p>Neither the Administrative Assistant nor the Director of Nursing was able to provide any further documentation and/or information when asked on 02/04/14 at 1:30 PM.</p>		<p>auditing of these specific items to be initiated by the Quality Review Team starting 3/3/2014. Reports of any discrepancies to the Clinical Supervisor will be on-going on a weekly basis. 3. The Clinical Director is responsible for over-all monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.</p>		

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	<p>4. Clinical record number 12 included a plan of care established by the physician for the certification period 07/05/13 to 09/02/13 with orders for skilled nursing services for 2 times a week for 2 weeks with 3 prn visits. On 07/14/13, the skilled nurse visits were extended to 3 times for 1 week. The clinical record evidenced only 2 skilled nursing visits was made during the week of 07/14/13. On 07/22/13 the skilled nurse visits was extended to 3 times for 1 week. The clinical record evidenced 4 skilled nurse visits and 1 home health aide visit during the week of 07/22/13.</p> <p>The Director of Nursing indicated the third skilled nurse visit was supposed to be a prn visit. The Alternate Administrator and Director of Nursing were unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>5. Clinical record number 15 included a plan of care established by the physician for the certification period 06/20/13 to 08/18/13 with orders for skilled nursing services for 1 time during week one and 3 prn visits. The clinical record evidenced 2 skilled nursing visits during week one. On 07/14/13, the skilled</p>			

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N000541	<p>nurse visits were extended to 1 time a week for 5 weeks. The clinical record evidenced 2 skilled nursing visits during the week of 07/15/13.</p> <p>The Director of Nursing indicated the third skilled nurse visit was supposed to be a prn visit. The Alternate Administrator and Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <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. Based on clinical record and interview, the agency failed to ensure the skilled nurses regularly re-evaluated the patient's nursing needs for 1 of 16 records reviewed. (# 13) This had the potential to affect all patients who were receiving services from the agency.</p> <p>Findings include:</p>	N000541	<p>N 541 410 IAC 17-14-1(a)(1)(B) SCOPE OF SERVICES: To ensure that the registered nurse regularly re-evaluates the patient's nursing needs (except in cases that are limited to therapy only), the following corrective action steps have been taken: 1. The education plan for 2/25/2014 and 2/28/2014 is to emphasize to staff the importance of re-evaluation and expectation of immediate follow up with all</p>	02/28/2014

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N000542	<p>1. Clinical record number 13 included a plan of care established by the physician for the certification period 07/06/13 to 09/02/13. A skilled nursing note dated 08/06/13 at 08:48 AM, indicated the patient had called into the agency indicated leg discomfort and he could not wait for a nursing visit on 08/08/13. The clinical record failed to evidenced a visit was made on 08/06/13 and 08/07/13 to reevaluate the patient's needs.</p> <p>2. The Alternate Administrator and Director of Nursing was unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <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 clinical record and policy review and interview, the agency failed to ensure a Registered Nurse made necessary revisions on a plan of care in relation to a pressure wound for 1 of 4 records reviewed of patients with wound care. (#1) This had the potential for</p>	N000542	<p>untoward clinical situations. 2. To maintain compliance, it is the responsibility of the Quality Review Team member to report audit results immediately if a discrepancy is discovered and on an on-going basis. 3. The Clinical Director will be responsible for the over sight of these corrective actions, starting on 3/4/2014. 4. The particular issue raised in the record reviewed by the surveyor deals with an employee who is no longer with the agency. Disciplinary actions were taken with him prior to his leaving the agency on 9/24/2013.</p> <p>N542 410 IAC 17-14-1(a)(1)(C) SCOPE OF SERVICES: To ensure that the plan of care is initiated and necessary revisions made by the registered nurse, the following action steps will be taken: 1. Clinical staff will be educated on 2/25/2014 and 2/28/2014 on the need to follow,</p>	02/28/2014			

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	<p>affect all patients receiving services from this agency.</p> <p>Findings include:</p> <p>1. Clinical record # 1 included a plan of care established by the physician for the certification period 12/07/13 to 02/04/14 that included orders for skilled nursing to assess signs/symptoms of infection / deterioration of wounds. The Admission Comprehensive Assessment dated 12/07/13 indicated the patient had a pressure wound to the coccyx. The clinical record failed to evidenced wound care was included in the plan of care.</p> <p>The Alternate Administrator indicated the nurses wound care to the coccyx should have been included in the plan of care.</p> <p>2. A policy titled "Plan of Care" dated 09/03/12, indicated "The total Plan of Care shall be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires ... "</p>		<p>review, and update all treatment and medication orders according to the Plan of Care policy. a. Specific examples:</p> <p>i. Measure any and all wounds on a weekly basis according to policy.</p> <p>ii. Document all medications on the Medication Profile.</p> <p>iii. Document the size of the Huber needle with each port access. 2. These specific education components will be taught by the Clinical Educator/Clinical Director. Auditing of these specific items to be initiated by the Quality Review Team starting 3/4/2014. Reports of any discrepancies to the Clinical Supervisor will be on-going on a weekly basis to maintain compliance. 3. The Clinical Director is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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N000546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the physician was informed of a patient's change in condition (# 3 and # 9), early discharges (# 10, # 11, # 15 and # 16) for 7 of 16 records reviewed, and the need to approve or cosign written prescription orders from a Nurse Practitioner (# 6) creating the potential to affect all of the agency's 194 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a physical therapy note dated 01/10/14 that stated, "pts [patient's] wife had called office and office called therapist to report pt possible had a stroke/tia [transient ischemic attack] thus wanted to cancel therapy today as pt not up to it." The clinical record failed to evidenced the physician was notified of</p>	N000546	<p>N546 410 IAC 17-14-1(a)(1)(G) SCOPE OF SERVICES: To ensure that the registered nurse (except in cases that are limited to therapy only), informs the physician of changes in the patient's condition and needs, the follow action steps have been initiated: 1. Education will be provided to the professional clinical staff on the dates of 2/25/2014 and 2/28/2014 on the specific items of: a. Timely notification of the physician of any change in condition b. NP orders are co-signed by attending physician prior to implementation c. Physician notification of a discharge. 2. These specific education components will be taught by the Clinical Educator/Clinical Director. Auditing of these specific items to be initiated by the Quality review Team starting 3/4/2014. Reports of any discrepancies to the Clinical Supervisor will be on-going on a weekly basis to</p>	02/28/2014

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	<p>the patient's change in condition.</p> <p>2. Clinical record number 6 included signed prescriptions by a Nurse Practitioner dated 04/05/13, 04/26/13, and 08/08/13 for 1 liter of Normal Saline Intravenous to be given 3 times a week through the patient's implanted port. The clinical record failed to evidenced the physician was notified and verified the Nurse Practitioner's order.</p> <p>The Director of Nursing was unable to provide documentation the physician was notified prior to the administration of intravenous fluids.</p> <p>3. Clinical record number 9 included a skilled nurse visit note dated 01/06/14 that stated,"Wt [weight] gain of 8 lbs [pounds] since Saturday ... Pt states extra swelling in legs ..." The clinical record failed to evidenced the physician was notified of the patient's change in condition.</p> <p>4. Clinical record number 10 included plan of care established by the physician for the certification period 07/27/13 to 09/24/13. The clinical record evidenced a discharge oasis assessment dated 8/29/13. The clinical record failed to evidenced the physician was notified</p>		<p>maintain compliance. 3. The Clinical Supervisor will be responsible for monitoring these corrective actions of the timely notification of the physician and the physician notification of discharge to ensure that this deficiency is corrected and will not recur, starting the week of 3/4/2014.</p> <p>4. The Regulatory Director will be responsible for monitoring the co-signed NP orders received by the agency.</p>	

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	<p>prior to the early discharge.</p> <p>5. Clinical record number 11 included a plan of care established by the physician for the certification period 08/20/13 to 10/18/13. The clinical record evidenced a discharge oasis assessment dated 09/18/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>6. Clinical record number 15 included a plan of care established by the physician for the certification period 06/20/13 to 08/18/13. The clinical record evidenced a discharge oasis assessment dated 08/06/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>7. Clinical record number 16 included a plan of care established by the physician for the certification period 07/02/13 to 08/30/13. The clinical record evidenced a discharge oasis assessment dated 08/06/13. The clinical record failed to evidenced the physician was notified prior to the early discharge.</p> <p>8. A policy titled "Medical Supervision" dated 09/03/12 stated, "Physician will be contacted when any of the following occurs: Condition changes ... expected response to treatment ... Any change in</p>						

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N000567	<p>patient condition or agency services ... "</p> <p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on clinical record and policy review and interview, the agency failed to ensure the case manager was informed of a patient's change in condition (# 3) for 1 of 9 clinical records reviewed of patients receiving therapy services creating the potential to affect all of the agency's patients that receive therapy services.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a physical therapy note dated 01/10/14 at 10:45 AM that stated, "pts [patient] wife had called office and office called therapist to report pt possibly had a stroke/tia [transient ischemic attack] thus wanted to cancel therapy today as pt not up to it." The clinical record failed to evidenced the case manager was notified of the patient's change in condition.</p>	N000567	<p>N567 410 IAC 17-14-1(c)(6) SCOPE OF SERVICES: To ensure that the therapist shall advise and consult with the family and other home health agency personnel, the following corrective actions have been implemented: 1. Education will be provided to all clinicians on 2/25/2014 and 2/28/2014 on the correct use of the Allscripts Routine Visit template Care Management: Care/Case Coordination: "communicated with (checkbox option)." Emphasis is on the PTA use of this to communicate with the PT on a per visit basis. The therapist is expected to document here the communication with the Case Manager, when a change in condition occurs. 2. In addition to this documentation, specific, detailed explanation of the conversation is to be included in the comment section of the assessment, with the status of the progress toward goals, continuation, or change in the</p>	02/28/2014			

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N000570	<p>The Alternate Administrator and the Director of Nursing were unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.</p> <p>2. A policy titled "Therapy Services" dated 06/11, indicated "The therapist will consult and collaborate with the registered nurse who is the case manager ... "</p> <p>410 IAC 17-14-1(d) Scope of Services Rule 14 Sec. 1(d) In carrying out the responsibilities identified in subsection (c) of this rule the therapist may: (1) direct the activities of any therapy assistant; or (2) delegate duties and tasks to other individuals as appropriate. Based on clinical record and policy review and interview, the agency failed to ensure all the physical therapist supervised the physical therapy assistant for 6 of 9 records reviewed of patients receiving therapy services. (# 3, # 4, # 5, # 9, # 10, and # 12). This had the potential to affect all patients who received therapy services with the agency.</p>	N000570	<p>plan of care documented. 3. Monitoring of the use of this communication piece, including the Care Management and accompanying comment will be done by a member of the Quality Review Team starting on the 4rd of March, 2014 and continue on an on-going basis to ensure compliance. 4. It is the responsibility of the Quality Review Team member to report audit results to the Clinical Director on a weekly basis. 5. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>N570 410 IAC 17-14-1(d) SCOPE OF SERVICES: To ensure that the therapist directs the activities of any therapy assistant and delegates duties and tasks as appropriate, the following action steps have been taken: 1. All professional clinical staff will be educated on the need to communicate patient status between the PTA and PT and with the case manager and the physician, including review of policies Care Coordination,</p>	02/28/2014

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 3, SOC (start of care) 12/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant. 2. Clinical record # 4, SOC 12/13/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant. 3. Clinical record # 5, SOC 11/27/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant. 4. Clinical record # 9, SOC 12/23/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant. 		<p>Therapy Services, and Supervision of Therapy Assistants on 2/25/2014 and 2/28/2014 by the Clinical Educator/Clinical Director. 2. Monitoring of this communication piece, including the Care Management and accompanying comment will be done by a member of the Quality Review Team member starting on the 4rd of March and continue on an on-going basis to ensure compliance. 3. It is the responsibility of the Quality Review Team member to report audit results of documentation discrepancies to the Clinical Director on a weekly basis. 4. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>5. Clinical record # 10, SOC 07/27/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>6. Clinical record # 12, SOC 07/05/13, evidenced the patient was receiving physical therapy services. The clinical record failed to evidenced documentation of coordination of care among the physical therapist and the physical therapist assistant.</p> <p>The Administrator indicated the employees should had documented their communications between each other. The Alternate Administrator indicated physical therapy assistants would contact the physical therapist daily.</p> <p>7. A policy titled "Communication Sheet" dated 6/21/11, indicated "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting</p>			

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	<p>weekly by the PCC ... "</p> <p>8. A policy titled "Supervision of Physical Therapy Assistant by Licensed Physical Therapist" dated 06/11, indicated "The Physical Therapist will be available to, and responsible for, the direction and actions of the Physical Therapy Assistant in the performance of the direct care given by the Physical Therapy Assistant to the home care client. The Physical Therapist and the Physical Therapy Assistant consult each day a patient is seen to review all home care clients' treatments and progress toward goals ... The PTA (physical therapy assistant) will consult and document such with the supervising PT (physical therapist) at least once each day a patient is seen to review all patient treatments "</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> <ol style="list-style-type: none"> (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>Based on clinical record review and interview, the agency failed to ensure skilled nurses documented how wound care / treatment was provided for 3 of 4 patient's reviewed who had treatment orders. This had the potential to affect all patients with treatment orders who currently receive services from the agency. (#5, # 15, and #16).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 5 included a plan of care established by the physician for the certification period 11/27/13 to 01/25/14. The clinical record identified 	N000608	<p>N 608 410 IAC 17-15-1(a)(1-6) CLINICAL RECORDS: To ensure that the clinical records contain pertinent past and current findings in accordance with accepted professional standards, the following action steps will be taken: 1. The professional nursing staff will review the expectations of wound care/ treatments documentation. This education will take place 3/4/2014 by the Clinical Educator/Clinical Director. 2. Wound care/treatments intervention documentation is to be monitored for compliance on an on-going basis by a member of the Quality Review Team and discrepancies are reported to the Clinical</p>	03/04/2014

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	<p>skilled nurses provided wound care on 11/27/13, 12/03/13, 12/06/13, 12/09/13, 12/13/13, 12/17/13, 01/01/14, 01/08/14, 01/21/14, 01/22/14, and 01/24/14. The clinical record failed to evidenced written documentation on how wound care was provided by the skilled nurse.</p> <p>2. Clinical record number 15 included a plan of care established by the physician for the certification period 06/20/13 to 08/18/13. The clinical record identified skilled nurses provided wound care on 06/20/13, 06/22/13, 06/25/13, 06/28/13, 07/01/13, 07/05/13, 07/08/13, 07/12/13, 07/16/13, 07/18/13, 07/23/13, and 07/26/13. The clinical record failed to evidenced written documentation on how wound care was provided by the skilled nurse.</p> <p>3. Clinical record number 16 included a plan of care established by the physician for the certification period 07/02/13 to 08/30/13. The clinical record identified skilled nurses provided wound care on 07/02/13, 07/05/13, 07/08/13, 07/10/13, 07/12/13, 07/15/13, 07/17/13, 07/18/13, 07/19/13, 07/24/13, 07/31/13, and 08/02/13. The clinical record failed to evidenced written documentation on how wound care was provided by the skilled nurse.</p>		Supervisor. 3. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	4. The Alternate Administrator and Director of Nursing were unable to provide any additional documentation and/or information when asked on 02/04/14 at 1:30 PM.			