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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157115 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/30/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>GENTIVA HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8606 ALLISONVILLE RD STE 350<br>INDIANAPOLIS, IN 46250 |
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| G 000<br><br>Bldg. 00 | <p>This was a federal home health agency recertification survey. This was a partial extended survey.</p> <p>Facility # 005306</p> <p>Survey Dates were 3/23/15-3/27/15, 3/30/15</p> <p>Census<br/>Parent 1229<br/>Branch 711</p> <p>QA:JE 4/10/15</p>   | G 000         |   |                      |
| G 110<br><br>Bldg. 00 | <p>484.10(c)(2)(ii)<br/>RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as</p> |               |   |                      |

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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|                    | <p>the information is furnished before care is provided.</p> <p>Based on clinical record and agency policy review, the agency failed to ensure the physician had signed the patient's advanced directive for 1 of 20 records reviewed. (patient #2.)</p> <p>Findings include:</p> <p>1. Clinical Record #2 evidenced the document State of Indiana Out of Hospital Do Not Resuscitate Declaration dated 1/29/15 and signed by the patient and the nurse was not signed by a physician.</p> <p>2. Gentiva Health Services Undated Policy 3-10 titled "Advanced Directives" states, "All adult patients have the right to participate in and direct their health care decisions . . . This right may be expressed verbally or in writing using a "living will, health care proxy, power of attorney, or other provisions in state law and regulation . . . This will be documented in the clinical record in a consistent location in all office clinical records. If the advance directive includes a Do Not Resuscitate (DNR) provision and there is reason to believe that it will be necessary to implement the provisions of the advance directive, the office will obtain physician orders on the Plan of</p> | G 110         | <p><b>G 110 484.10(c)(2)(II) RIGHT TO BE INFORMED AND PARTICIPATE</b> The HHA complies with the requirements of Subpart I of 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. <b>Corrective Action:</b> a. Patient #2 physician was contacted on March 25, 2015 to follow up on out-of-hospital DNR documentation. b. Orders were received on March 25, 2015 for Social Work Evaluation that was completed on March 27, 2015. c. Staff RN responsible for Start of Care on patient #2 no longer employed by Gentiva Health Services. d. Manager of Clinical Practice who performed start of care case conference on Oasis start of care for patient #2 was educated on branch process for patients who wish to complete DNR out-of-hospital form. <b>Education:</b> a. Administrator or</p> | 04/29/2015           |

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| G 158<br>Bldg. 00  | <p>treatment or another document . . .</p> <p>Pertinent advance directive information will be communicated to all clinicians in a consistent manner (e.g., Patients who have a DNR directive may have a red sticker placed on their record and in home record). This information will be documented on the Personal Care plan for all Personal Care Workers. "</p> <p>484.18<br/>ACCEPTANCE OF PATIENTS, POC, MED SUPER<br/>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.<br/>Based on clinical record review, observation, interview, and agency policy review, the agency failed to ensure the physician was notified of missed visits and treatments were provided as ordered for 2 of 20 records reviewed (#1, #4)</p> <p>Findings:</p> <p>1. Clinical record number 1, included a plan of care for the certification period, 2/15/15 to 4/15/2015 with orders for an aide frequency 3 x a week for 2 weeks starting 2/15/2015 (week 2) and 2x a week for 7 weeks starting 3/01/2015. The</p> | G 158         | <p>designee will in-service all staff regarding informing and distributing written information to the patient concerning the advanced directives.</p> <p><b>Monitoring:</b> a. Administrator or designee will review 20 charts per week for 5 weeks starting April 20, 2015 for evidence of advanced directive assessment and documentation during Oasis start of care visit. Once 95% compliance reached, monitoring will continue through the Quarterly clinical record review process.</p> <p><b>G 158 418.48 ACCEPTANCE OFPATIENTS, POC,MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Corrective Action:</b><br/>a. Patient #1: Physician was notified on March 31, 2015 via phone of home health aide missed visits on February 16, 2015 (patient not home), February 27, 2015 (patient refused visit),and March 3, 2015 (patient has a physician appointment). b. Patient #4:Physician notified on March 26, 2015 of home health</p> | 04/29/2015           |

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|   | <p>agency</p> <p>A. Clinical record number 1 evidenced an aide had missed a visit on 2/16/15. A Missed visit note dated 2/18/15 stated the reason for the missed visit was "no answer to locked door." It is not documented that the physician was notified.</p> <p>B. Clinical record number 1 evidenced an aide had missed a visit on 2/27/15. A missed visit note dated 2/27/15 stated a reason for the missed visit was "patient/caregiver refused visit." It is not documented that the physician was notified.</p> <p>C. Clinical record #1 included a skilled nurse (SN) noted 2/17/15 that identified the patient had sutures on his head and the spouse was applying bacitracin. The plan of care dated 2/15/15 failed to evidence bacitracin was ordered to be applied to the patient's sutures.</p> <p>2. Clinical record number 4, included a plan of care for the certification period 2/17/2015 to 4/17/2015 with orders for aide services 3x a week for 3 weeks starting 2/22/2015, 2x a week for 2 weeks starting 3/15/2015, 1x a week for 3 weeks starting 3/29/2015.</p> |   | <p>aide missed visits: February 5, 2015 and March 13, 2015 patient did not answer the door. c. 100% of active patients reviewed for evidence of missed HHA visits being documented and physician notified April 21, 2015. d. Administrator or designee will provided 1:1 education to staff involved in providing care for patients #4 d. For patient #1, Patient's spouse had reported applying bacitracin on the patient's wound at some time during certification period starting February 15, 2015, but at the time of the survey visit this had been discontinued. <b>Education:</b> Administrator or designee will provide education to all clinical staff on missed visit process for notifying the physician and for obtaining orders for all treatments provided in the home. <b>Monitoring:</b> Administrator or designee will review 20 charts per week for 5 weeks starting April 20, 2015 for evidence of physician notification of all missed visits and physician orders obtained for all interventions provided. Once 95% compliance reached, monitoring will continue through the Quarterly clinical record review process.</p> |                      |   |

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|                    | <p>A. Clinical record number 4 evidenced an aide had missed a visit on 3/5/2015. A missed visit note dated 3/10/15 stated the reason was "patient/caregiver refused." There was no documentation the physician was notified.</p> <p>B. Clinical record number 4 evidenced an aide had missed a visit on 3/11/2015. A missed visit note dated 3/13/2015 stated the reason was "no answer to locked door/phone." There is no documentation the physician was notified.</p> <p>3. Gentiva Policy 03-12 Revised 12/18/2012, titled "Physician Orders," section "Notices to the Physician", states ". . . The office will notify the physician if the patient refuses service or treatment ordered and will document the refusal in the clinical record. If fewer visits are provided during the week than ordered, the physician will be notified with documentation in the clinical record that the physician is aware of the missed visit . . ."</p> <p>4. Gentiva Agency Policy 03-12 Revised 12/18/2012 titled "Physician's Orders" states, "Content of Physician Orders. The Plan of Care is based on an evaluation of</p> |               |   |                      |

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| G 159<br>Bldg. 00  | <p>the patients immediate and long term needs. It covers all pertinent diagnosis, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatment, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items . . . "</p> <p>484.18(a)<br/>PLAN OF CARE<br/>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.<br/>Based on record review, interview, and</p> | G 159         | <b>G159 484.18(a) PLAN OF CARE</b>  | 04/29/2015           |

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|                    | <p>agency policy review, the agency failed to develop the plan of care to include accurate functional limitations and activities permitted for 3 of 20 records reviewed. (#2, #3, #4.)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #2 included A Comprehensive Adult Oasis Form dated 1/31/2015. Under Fall Risk Reduction/Prevention it states, "Client must use walker at all times and a stand by assist is recommended" and "Equipment: care/safety: Client must use walker at all times." The Plan of Care dated 1/29/2015 failed to evidence the activities permitted (18B walker).</li> <li>2. Clinical record #3 included a Plan of Care dated 1/7/2015 that failed to evidence activities permitted (18B Wheel chair or Walker) or all functional limitations.</li> <li>3. Clinical record #4 included a Plan of care dated 2/17/15 that failed to evidence the activities permitted, (18B Walker). On the goals/rehabilitation potential/discharge Plans 2/17/15 include, "Use rolling walker at all times."</li> <li>4. In an interview with registered nurse (RN), employee O, on March 24, 2015 ,</li> </ol> |               | <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnosis, including mental status, types of serviceand 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><b>Corrective Action:</b> a. Patient #2: A comprehensive assessment was completed on March 25, 2015 and subsequent plan of care lists activities permitted. b. Patient #3: This patient was discharged from the agency to hospice onMarch 27, 2015. c. Patient #4: A comprehensive assessment was completed April 13, 2015 and subsequent plan of care lists activities permitted. 100% of active patients reviewed for presence of appropriate documentation of activities permitted on plan of care April 20, 2015. Administrator or designee will provide 1:1 education to staff involved in the provision of care to patient #2, #3, and #4 regarding activities permitted in completing the plan of care worksheet. <b>Education:</b> Administrator or designee will provide education to all professional staff on developing the plan of care to include</p> |                      |

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|   | <p>at 10:30 AM the nurse stated, "There seems to be a computer glitch in which some of the items from the assessment are not populating the form. This comes from the assessment, but there are other places that things like this are documented."</p> <p>5. Gentiva Agency Policy 03-12 Revised 12/18/2012, titled "Physician's Orders" states, "Content of Physician Orders. The Plan of Care is based on an evaluation of the patients immediate and long term needs. It covers all pertinent diagnosis, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatment, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items . . . "</p> |   | <p>accurate functional limitations and activities permitted.<br/><b>Monitoring:</b> Administrator or designee will review 20 charts per week for 5 weeks starting April 20, 2015 for evidence of functional limitations and activities permitted on the plan of care. Once 95% compliance reached, monitoring will continue through quarterly clinical record review.</p> |                      |   |
| G 172<br>Bldg. 00   | <p>484.30(a)<br/>DUTIES OF THE REGISTERED NURSE<br/>The registered nurse regularly re-evaluates the patients nursing needs.<br/>Based on clinical record review, interview, and agency policy review, the agency failed to ensure the registered</p>   | G 172   | <p><b>G 172 484.30(a) DUTIES OF THE REGISTERED NURSE</b> The registered nurse regularly</p>   | 04/29/2015           |   |

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|                    | <p>nurse accurately and completely assessed the patient's wound for 2 of 20 records reviewed (Clinical record #1 and #3.)</p> <p>Findings include:</p> <p>1. Clinical record #1 contained a skilled nurse note assessment dated 2/20/15 that identified the patient had a normal integumentary system. A Skilled nursing narrative note dated 2/20/15 indicated the patient had sutures on the head. The note failed to evidence any assessment of the wound.</p> <p>A. Clinical record #1 contained a skilled nurses note dated 2/25/15 states, " Incision to forehead, sutures removed except one and healing well, new incision to his right eye at side." A skilled nursing clinical note dated 2/27/15 identified a normal integumentary system. A skilled nursing note dated 3/3/15 identified a normal integumentary system. The note failed to evidence any assessment of the wound.</p> <p>B. In an interview with registered nurse (RN), Employee O, on 3/27/15 at 3:10 PM,the RN states, " I would expect to see a measurement and the number of sutures on onset of this discovery."</p> <p>2. Clinical Record #3 contained an</p> |               | <p>re-evaluates the patients nursing needs. <b>Corrective Action:</b> a. Patient #1. Wound on patient's temple area reported by spouse during survey visit. At this time the wound was already healed. During joint visit with surveyor, both surveyor and MCP observed that temple incision was healed and without sign and symptoms of infection. On March 27, 2015, after consulting with physician, patient had SN discipline discharge at which time skin assessment indicated intact skin and no problems were identified. b. Patient #3. On March 25, 2015, joint visit made with surveyor to observe HHA visit, caregiver reported the wound from lumpectomy under left breast, that she had been caring for, was healed. Both MCP and surveyor observed a healed incision under left breast with no signs and symptoms ofinfection and no problems were identified. c. Individual clinicians responsible for wound assessments/care for Patients #1, #3 have been educated regarding Gentiva standards for Skilled Nursing Assessment(s) and management of patient wounds. Completion Date: 4/14/15 <b>Education:</b> a. Administrator or designee will educate all field staff clinicians (who perform wound care) regarding appropriate assessments to include but not limited to wound Management, wound Staging and Wound</p> |                      |

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|                    | <p>OASIS Inpatient Facility Transfer Document dated 2/9/2015 which states, "Patient had a lumpectomy last Thursday and she did well . . ." The skilled nursing plan of care worksheet dated 2/19/15 does not address observations, assessment, or integumentary interventions, or any goals related to wound. The physical therapy resumption of care on 2/14/15 failed to assess the surgical incision. The RN evaluation with skilled nursing visit dated 2/19/2015 failed to assess and document location, size, appearance or any description of the surgical incision. A Skilled visit note dated 2/24/15 also failed to evidence assessment of the surgical incision, stating, "No problems identified/skin intact."</p> <p>In a telephone interview with the patient's caregiver on March 24, 2015, at 4:00 PM, it was stated, " There was drainage from (The patients) left breast where a lump had been. The doctors drained some fluid on January 15th. They did surgery on it February 5th and then she went back into the hospital the following week with a urinary tract infection. The incision under the breast was about 3 or 4 inches. Its healed."</p> <p>3. Gentiva Health Services Policy, titled Wound Care 10-39 Revised 5/16/2012</p> |               | <p>Documentation. 1. All professional staff to complete Gentiva University Courses:<br/>a.AboutWound Care:<br/><i>Identification and Assessment 1.5 Hours.</i> b. <i>Documenting wound care effectively .7 Hours</i> 2. All nurses will be signed off in practicum facilitated/supervised by administrator or designee utilizing wound mannequin.<br/><b>Monitoring:</b> Administrator or designee will review 20 charts per week for 5 weeks starting April 20, 2015 forevidence of SN assessing patient's wounds per Gentiva policy and following physician orders for wound care treatment/dressing changes. Once 95% compliance reached, monitoring will continue through quarterly clinical record review.</p> |                      |

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| G 176<br>Bldg. 00  | <p>states, . . . " Even though a wound may not require skilled nursing to perform the care, the wound may require skilled observation and evaluation for signs and symptom of infection or complications . . . "</p> <p>4. Gentiva Health Services Policy, titled, Assessment 03-05, Revised 10/23/2013 states . . . " At least weekly, the wound(s) status will be observed and documented, including dimensions (L x W x D in cm), drainage amount and type, wound bed appearance and surrounding skin condition. Communication of any unexpected change in condition will be communicated promptly to members of the patient's care team."</p> <p>484.30(a)<br/>DUTIES OF THE REGISTERED NURSE<br/>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.<br/>Based on interview and clinical record, agency document, and agency policy review, the registered nurse and agency failed to prepare clinical notes, including incident reports, fully describing and informing other personal in a change in a</p> | G 176         | <b>G 176 484.30(a) DUTIES OF THE REGISTERED NURSE</b> The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and | 04/29/2015           |

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|                    | <p>patient's condition (#10.)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>In an interview with licensed practical nurse (LPN), Employee L, on March 26, 2015, at 5:00 PM, two wounds on patient number 10 lower left leg were described during a dressing change. The LPN stated, "The lower one is from tape removal and the upper one was an accident with scissors during a dressing change." The record failed to evidence the incident report was written timely.</li> <li>Clinical record #10 evidenced a communication note to physician dated 2/16/15 that stated, "Left VM [voicemail] at Westview wound clinic notifying them of the incident on 2/14/2015 with a skin tear on the medial shin d/t [due to] tape tore the skin as being pulled off . . . ."</li> <li>An agency document titled "Patient Events Reported for Cost Center '00058' between 01/01/2015 and 03/31/2015, evidenced an incident report was not filed until 3/26/2015.</li> <li>In an interview with a Branch Manager, on 3/30/15 at 6:00 PM, employee M states, "This patient has not had a major functional decline. ... The notes reflect that. We're taking care of the</li> </ol> |               | <p>needs. <b>Corrective Action:</b> a. Individual corrective counseling completed on March 26, 2015 with nurses who provided care to patient #10 on Gentiva policy for incident reporting. <b>Education:</b> a. The HHA management team will receive 1:1 education on the policy/process for completing Incident Reports. b. All staff will complete: Gentiva University: <i>Incident Reporting Self-Paced Workbook</i>. c. Administrator or designee will educate all clinicians regarding Incident Reporting and Standards for Communication of the Change in Patient Condition. <b>Monitoring:</b> The administrator or designee will capture incident reports during morning stand-up calls. The Administrator or designee will also capture and review incidents during weekly location meetings. The administrator or designee will compare the meeting notes to the online incident reported every week for 5 weeks to ensure compliance. Once 95% compliance is achieved; further monitoring will be incorporated into the quarter advisory committee meetings QAC.</p> |                      |

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| G 186<br>Bldg. 00  | <p>patient, the patient and the wound center are agreeable."</p> <p>5. The undated Gentiva Policy 5-18 "Patient Incident Reporting and Sentinel Events" states, "All staff will report to the location, clinical manager or designee any unusual occurrence, variance in providing patient care, protects or services that result or could potentially result in injury or harm to the patient. Following receipt of the report, the location manager will promptly investigate and document all facts of the incident in the incident reporting system . . . Incidents will be reported to the location, clinical manager, or designee immediately after they occur. "</p> <p>484.32<br/>THERAPY SERVICES<br/>The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)</p> <p>Based on document review and interview, the agency failed to ensure the speech therapist accurately completed the patient's "Speech Therapist Plan of Care Worksheet" dated 3/9/15 for 1 of 1 record reviewed of patients receiving speech therapy. (#1)</p> <p>Findings include:</p> | G 186         | <p><b>G 186-484.32</b> The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary). <b>Corrective Action:</b></p> <p>a. Speech therapist educated pt#1 and family on diet ordered by physician on March 31, 2015.</p> <p><b>Education:</b> a. Administrator or designee will complete 1:1 education to both speech therapists involved in the care of</p> | 04/29/2015           |

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| G 321<br>Bldg. 00  | <p>1. The "Speech Therapist Plan of Care Worksheet" dated 3/9/15 for patient #1 evidenced the therapist marked that the patient was a mechanical soft diet.</p> <p>2. On 3/25/15, the patient's spouse indicated the patient returned from a hospitalization right before the start of care on a regular diet.</p> <p>484.20(a)<br/>ENCODING OASIS DATA<br/>The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set.</p> <p>Based on document review, the agency failed to ensure that all assessments were transmitted within 30 days of the M0090 date for 1 of 1 agency.</p> <p>Findings Include:<br/><br/>The Casper Report "HHA Error Summary Report by Agency" from</p> | G 321         | <p>patient #1 regarding following physician orders in plan of care.<br/>b. Administrator or designee will complete education to all Speech Therapists to review the terminology that is used in documentation regarding diet accurately reflects the ordered patient's diet based on standard definitions set by American Speech-Language-Hearing Association (ASHA)( i.e,regular, mechanical soft, purred etc.)<br/><b>Monitoring:</b> Administrator or designee will review 5 charts per week for 5 weeks starting April 20, 2015 forevidence of completion and accuracy of diet section of Oasis document. Once 95% compliance reached, monitoring will continue through quarterly clinical record review.</p> <p><b>G321 484.20 Encoding Oasis Data.</b> The HHA must encode and be capableof transmitting OASIS data for agency patient within 30 days of completing theOASIS data set. <b>Corrective Action:</b> Administrator or designee will review 100% of transmissions of Oasis data on a weekly basis. Completion date: Ongoing.<br/><b>Education:</b> a. Administrator or designee will in-service the MCP (Managers ofClinical Practice)</p> | 04/29/2015           |

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| G 337<br>Bldg. 00  | <p>9/2014 to 02/2015 identified the agency had 16.45 % of the submitted assessments transmitted later than 30 days after the M0090 date.</p> <p>484.55(c)<br/>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 record review, interview, observation, and agency policy review, the agency failed to ensure medication history was accurately identified on the Medication profile for 3 of 20 records reviewed (#1, #4, #10.)</p> <p>The findings include:</p> <p>1. Patient record number 1 included a Skilled Nursing Note dated 2/17/15 that evidenced the patient's spouse was applying bacitracin to stitches on the top of the patients head. Bacitracin is not listed on the Medication Profile for the</p> | G 337         | <p>regarding Gentiva policy and process for timely completion of Oasis assessments.</p> <p><b>Monitoring:</b> Administrator or designee will review all Oasis transmissions for 5 weeks starting April 13, 2015 forevidence of timely transmission. Once 95% compliance reached, monitoring will continue through quarterly clinical record review.</p> <p><b>G 337 484.55 The comprehensive assessment must include a review of all medications the patient is currently using in order to identify and potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicative drug therapy, and noncompliance with drug therapy. Corrective Action:</b> a. Medication reconciliation, review, and medication profile update was immediately completed for those patients cited under G337(Patient(s) #1, #4, #10).</p> | 04/29/2015           |

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|                    | <p>dates of 2/15/15- 4/15/15.</p> <p>2. Patient record number 4, "Home Health Certification and Plan of Care" for certification period 2/17/15 to 4/17/2015, evidenced the patient had been on Lasix 60 Milligram tablets, 1 tab Twice per day, oral. (120 milligrams total per day).</p> <p>A. Patient record number 4 Medication Profile document dated 3/24/15, last electronically signed by licensed practical nurse (LPN), employee Q, documented that the start date of Lasix 2/17/2015 dose was 20 mg. 1 tab, twice per day, oral (40 milligrams total per day.)</p> <p>B. In an interview with the Manager of Clinical Practice, Employee O, on March 25, 2015, at 1:30 PM, employee O stated, "It is our policy that when there is a change in medication that the order , including start date, route, strength, amount and frequency is maintained on its own line, marked by a D/C [discontinue] date and the new order, on its own line is written with the new start date, medication, route, strength, amount and frequency. The original dose was inadvertently deleted."</p> <p>C. A. Patient number 4 included a plan of care for certification period</p> |               | <p>Completion Date: April 17, 2015.</p> <p>b. Individual clinicians responsible for medication reconciliation for those patients cited under G337 (Patient(s) #1, #4, #10) have received 1:1 education regarding Gentiva standards for Medication Reconciliation and management of the Patient's Medication Profile. Employees return demonstrated the process for changing the dosage of a current medication c. Supervisory visits for medication reconciliation will be made April 22, 2015 for clinician who treated patient #1, #4. Supervisory visit for medication reconciliation completed April 16, 2015 for clinician who treated patient #10. (Patient(s) #1, #4, #10) d. For patient #1, Patient's spouse had reported applying bacitracin on the patient's wound at some time during certification period starting February 15, 2015, but at the time of the survey visit this had been discontinued. e. For patient #4, Medications were reconciled with the patient and documented in the medical record on March 26 and March 27, 2015. f. For patient #10, Medications were reconciled with patient and documented in the medical record on March 30, 2015. <b>Education:</b> a. Administrator or designee will educate all clinicians regarding Medication Reconciliation, Use of the Patient Medication Profile Document and process for corrections/amendments to the Patient Medication Profile.</p> |                      |

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|                    | <p>2/17/15 to 4/17/2015 that failed to include oxygen. At the home visit on March 25, 2015, at 1:20 PM, the Patient was observed to be using oxygen, per nasal cannula at 3 Liters per minute</p> <p>D. Clinical record number 4, a "Physician Communication and Interim Order dated 3/27/2015 states, "Pt [patient] to be on 3-4 L [liters] Oxygen continuous per NC [nasal cannula]." The updated Medication profile dated 3/27/15 lists oxygen, "Oxygen NC 2 LPM [liters per minute] continuous flow."</p> <p>3. A home visit with patient #10 on March 26, 2015, at 4:30 PM evidenced an observation of the nurse applying Santyl to a wound on the lower left leg. Santyl was not listed on A medication profile dated 3/24/15 or on a medication profile dated 3/30/15. An order dated 2/12/2015 from the Physician stated to "apply santyl to left medial and lateral leg wound daily."</p> <p>4. Gentiva Health Services Policy 03-05 Revised 10/23/2013, states, "At the time of the initial assessment and each subsequent assessment, prescription, over-the-counter drugs, and herbals the patient is taking will be evaluated. Review will include viewing the bottles and labels of the drugs the patient has;</p> |               | <p><b>Monitoring:</b> Administrator or designee will review all new medication profile on admission or recertification for 5 weeks starting April 20, 2015 for evidence of a complete and accurate medication profile per Gentiva policy. Once 95% compliance reached, monitoring will continue through quarterly clinical record review.</p> |                      |

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| N 000<br>Bldg. 00  | <p>asking about other over-the-counter medications the patient is taking (including herbal preparations); asking the patient about when and how the patient is taking the medication; and asking the patient about potential side effects of the drugs . . . "</p> <p>5. Gentiva Health Services Policy 04-01 Revised: 05/30/14, states "Corrections, amendments, and/or late entries to the Electronic medical record must: Distinctly identify any amendment, correction, or delayed entry, and Provide a reliable means to clearly identify the original content, the modified content, and the date and name of the person making the change. All changes to the record are recorded in the audit trail with a date, time, and the name of the person making the changes."</p> <p>This was a state home health relicensure survey.</p> <p>Facility # 005306</p> | N 000         |   |                      |

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| N 518<br>Bldg. 00  | <p>Survey Dates were 3/23/15-3/27/15, 3/30/15</p> <p>Census<br/>Parent 1229<br/>Branch 711</p> <p>QA:JE 4/10/15</p> <p>410 IAC 17-12-3(e)<br/>Patient Rights<br/>Rule 12 Sec. 3(e)<br/>(e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record and agency policy review, the agency failed to ensure the physician had signed the patient's advanced directive for 1 of 20 records reviewed. (patient #2.)</p> <p>Findings include:</p> <p>1. Clinical Record #2 evidenced the document State of Indiana Out of Hospital Do Not Resuscitate Declaration dated 1/29/15 and signed by the patient and the nurse was not signed by a physician.</p> | N 518         | N-0518 410 IAC 17-12-3(e) PATIENT RIGHTS RULE 12 SEC. 3(e) (e) THE HOME HEALTH AGENCY MUST INFORM AND DISTRIBUTE WRITTEN INFORMATION TO THE PATIENT, IN ADVANCE, CONCERNING ITS POLICIES ON ADVANCE DIRECTIVES, INCLUDING A DESCRIPTION OF APPLICABLE STATE LAW THE HOME HEALTH AGENCY MAY FURNISH ADVANCE DIRECTIVE INFORMATION TO THE PATIENT AT THE TIME OF THE FIRST HOME VISIT, AS LONG AS THE INFORMATION | 04/29/2015           |

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| N 522<br>Bldg. 00   | <p>2. Gentiva Health Services Undated Policy 3-10 titled "Advanced Directives" states, "All adult patients have the right to participate in and direct their health care decisions . . . This right may be expressed verbally or in writing using a "living will, health care proxy, power of attorney, or other provisions in state law and regulation . . . This will be documented in the clinical record in a consistent location in all office clinical records. If the advance directive includes a Do Not Resuscitate (DNR) provision and there is reason to believe that it will be necessary to implement the provisions of the advance directive, the office will obtain physician orders on the Plan of treatment or another document . . . Pertinent advance directive information will be communicated to all clinicians in a consistent manner (e.g., Patients who have a DNR directive may have a red sticker placed on their record and in home record). This information will be documented on the Personal Care plan for all Personal Care Workers. "</p> <p>410 IAC 17-13-1(a)<br/>Patient Care<br/>Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established</p> |   | <p>IS FURNISHED BEFORE CARE IS PROVIDED <b>Corrective Action:</b> a. Patient #2 physician was contacted on March 25, 2015 to follow up on out-of-hospital DNR documentation. b. Orders were received on March 25, 2015 for Social Work Evaluation that was completed on March 27, 2015. c. Staff RN responsible for Start of Care on patient #2 no longer employed by Gentiva Health Services. d. Manager of Clinical Practice who performed start of care case conference on Oasis start of care for patient #2 was educated on branch process for patients who wish to complete DNR out-of-hospital form. Completion date: April 20, 2015. <b>Education:</b> a. Administrator or designee will in-service all staff regarding informing and distributing written information to the patient concerning the advanced directives. <b>Monitoring:</b> a. Administrator or designee will review 20 charts per week for 5 weeks starting April 20, 2015 for evidence of advanced directive assessment and documentation during Oasis start of care visit. Once 95% compliance reached, monitoring will continue through the Quarterly clinical record review process.</p> |   |  |   |  |

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|                    | <p>and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record review, observation, interview, and agency policy review, the agency failed to ensure the physician was notified of missed visits for 2 of 20 records reviewed (#1, #4)</p> <p>Findings:</p> <p>1. Clinical record number 1, included a plan of care for the certification period, 2/15/15 to 4/15/2015 with orders for an aide frequency 3 x a week for 2 weeks starting 2/15/2015 (week 2) and 2x a week for 7 weeks starting 3/01/2015. The agency</p> <p>A. Clinical record number 1 evidenced an aide had missed a visit on 2/16/15. A Missed visit note dated 2/18/15 stated the reason for the missed visit was "no answer to locked door." It is not documented that the physician was notified.</p> <p>B. Clinical record number 1 evidenced an aide had missed a visit on 2/27/15. A missed visit note dated 2/27/15 stated a reason for the missed visit was "patient/caregiver refused visit." It is not documented that the physician was notified.</p> | N 522         | <p>N 0522 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:<br/><b>Corrective Action:</b> a. Patient #1: Physician was notified on March 31, 2015 via phone of home health aide missed visits on February 16, 2015 (patient not home), February 27, 2015 (patient refused visit), and March 3, 2015 (patient had a physician appointment). b. Patient #4:Physician notified on March 26, 2015 of home health aide missed visits: February 5, 2015 and March 13, 2015 patient did not answer the door. c. 100% of active patients reviewed for evidence of missed HHA visits being documented and physician notified. Completed on April 21, 2015. d. Administrator or designee provided 1:1 education to staff involved in providing care for patients #4 Completed April 21, 2015 e Patient #1. Wound on patient's temple area reported by spouse during survey visit. At this time the wound was already healed. During joint visit with surveyor, both surveyor and MCP</p> | 04/29/2015           |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157115 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                    |  | X3) DATE SURVEY COMPLETED<br><br>03/30/2015 |                      |
| NAME OF PROVIDER OR SUPPLIER<br><br>GENTIVA HEALTH SERVICES |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8606 ALLISONVILLE RD STE 350<br>INDIANAPOLIS, IN 46250 |  |   |                      |
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|   | <p>C. Clinical record #1 included a skilled nurse (SN) noted 2/17/15 that identified the patient had sutures on his head and the spouse was applying bacitracin. The plan of care dated 2/15/15 failed to evidence bacitracin was ordered to be applied to the patient's sutures.</p> <p>2. Clinical record number 4, included a plan of care for the certification period 2/17/2015 to 4/17/2015 with orders for aide services 3x a week for 3 weeks starting 2/22/2015, 2x a week for 2 weeks starting 3/15/2015, 1x a week for 3 weeks starting 3/29/2015.</p> <p>A. Clinical record number 4 evidenced an aide had missed a visit on 3/5/2015. A missed visit note dated 3/10/15 stated the reason was "patient/caregiver refused." There was no documentation the physician was notified.</p> <p>B. Clinical record number 4 evidenced an aide had missed a visit on 3/11/2015. A missed visit note dated 3/13/2015 stated the reason was "no answer to locked door/phone." There is no documentation the physician was notified.</p> |   |  |   | <p>observed that temple incision was healed and without signs or symptoms of infection. On March 27, 2015, after consulting with physician, patient had SN discipline discharge at which time skin assessment indicated intact skin and no problems were identified. <b>Education:</b> Administrator or designee will provide education to all clinical staff on missed visit process for notifying the physician and for obtaining orders for all treatments provided in the home.</p> <p><b>Monitoring:</b> Administrator or designee will review 20 charts per week for 5 weeks starting April 20, 2015 for evidence of physician notification of all missed visits and physician orders obtained for all interventions provided. Once 95% compliance reached, monitoring will continue through the Quarterly clinical record review process.</p> |   |                      |

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| N 524              | <p>3. Gentiva Policy 03-12 Revised 12/18/2012, titled "Physician Orders," section "Notices to the Physician", states ". . . The office will notify the physician if the patient refuses service or treatment ordered and will document the refusal in the clinical record. If fewer visits are provided during the week than ordered, the physician will be notified with documentation in the clinical record that the physician is aware of the missed visit . . . "</p> <p>4. Gentiva Agency Policy 03-12 Revised 12/18/2012 titled "Physician's Orders" states, "Content of Physician Orders. The Plan of Care is based on an evaluation of the patients immediate and long term needs. It covers all pertinent diagnosis, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatment, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items . . . "</p> <p>410 IAC 17-13-1(a)(1)</p> |               |   |                      |

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| Bldg. 00           | <p>Patient Care</p> <p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on record review, interview, and agency policy review, the agency failed to develop the plan of care to include accurate functional limitations and activities permitted for 3 of 20 records reviewed. (#2, #3, #4.)</p> <p>Findings include:</p> <p>1. Clinical record #2 included A Comprehensive Adult Oasis Form dated 1/31/2015. Under Fall Risk Reduction/Prevention it states, "Client must use</p> | N 524         | N-0524 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (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 | 04/29/2015           |

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|                    | <p>walker at all times and a stand by assist is recommended" and "Equipment: care/safety: Client must use walker at all times." The Plan of Care dated 1/29/2015 failed to evidence the activities permitted (18B walker).</p> <p>2. Clinical record #3 included a Plan of Care dated 1/7/2015 that failed to evidence activities permitted (18B Wheel chair or Walker) or all functional limitations.</p> <p>3. Clinical record #4 included a Plan of care dated 2/17/15 that failed to evidence the activities permitted, (18B Walker). On the goals/rehabilitation potential/discharge Plans 2/17/15 include, "Use rolling walker at all times."</p> <p>4. In an interview with registered nurse (RN), employee O, on March 24, 2015 , at 10:30 AM the nurse stated, "There seems to be a computer glitch in which some of the items from the assessment are not populating the form. This comes from the assessment, but there are other places that things like this are documented."</p> <p>5. Gentiva Agency Policy 03-12 Revised 12/18/2012, titled "Physician's Orders" states, "Content of Physician Orders. The Plan of Care is based on an evaluation of</p> |               | <p>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 <b>Corrective Action:</b> a. Patient #2: A comprehensive assessment was completed on March 25, 2015 and subsequent plan of care lists activities permitted. b. Patient #3: This patient was discharged from the agency to hospice on March 27, 2015. c. Patient #4: A comprehensive assessment was completed April 13, 2015 and subsequent plan of care lists activities permitted. 100% of active patients reviewed for presence of appropriate documentation of activities permitted on plan of care April 20, 2015. Administrator or designee will provide 1:1 education to staff involved in the provision of care to patient #2, #3, and #4 regarding activities permitted in completing the plan of care worksheet. Completed April 20, 2015. <b>Education:</b> Administrator or designee will provide education to all professional staff on developing the plan of care to include accurate functional limitations and activities permitted. <b>Monitoring:</b> Administrator or designee will review 20 charts per week for 5 weeks starting April</p> |                      |

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| N 541<br><br>Bldg. 00                                       | <p>the patients immediate and long term needs. It covers all pertinent diagnosis, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatment, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items . . . "</p> <p>410 IAC 17-14-1(a)(1)(B)<br/>Scope of Services<br/>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:<br/>(B) Regularly reevaluate the patient's nursing needs.<br/>Based on clinical record review, interview, and agency policy review, the agency failed to ensure the registered nurse accurately and completely assessed the patient's wound for 2 of 20 records reviewed (Clinical record #1 and #3.)</p> <p>Findings include:</p> <p>1. Clinical record #1 contained a skilled nurse note assessment dated 2/20/15 that identified the patient had a normal</p> |   |  | N 541   | <p>20, 2015 for evidence of functional limitations and activities permitted on the plan of care. Once 95% compliance reached, monitoring will continue through quarterly clinical record review.</p> <p><b>N 541 410 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 EVALUATE THE PATIENT'S NURSING NEEDS</b> Corrective Action: a. Patient #1, Patient's spouse had reported applying bacitracin on the patient's wound</p> |   | 04/29/2015           |

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|                    | <p>integumentary system. A Skilled nursing narrative note dated 2/20/15 indicated the patient had sutures on the head. The note failed to evidence any assessment of the wound.</p> <p>A. Clinical record #1 contained a skilled nurses note dated 2/25/15 states, " Incision to forehead, sutures removed except one and healing well, new incision to his right eye at side." A skilled nursing clinical note dated 2/27/15 identified a normal integumentary system. A skilled nursing note dated 3/3/15 identified a normal integumentary system. The note failed to evidence any assessment of the wound.</p> <p>B. In an interview with registered nurse (RN), Employee O, on 3/27/15 at 3:10 PM,the RN states, " I would expect to see a measurement and the number of sutures on onset of this discovery."</p> <p>2. Clinical Record #3 contained an OASIS Inpatient Facility Transfer Document dated 2/9/2015 which states, "Patient had a lumpectomy last Thursday and she did well . . ." The skilled nursing plan of care worksheet dated 2/19/15 does not address observations, assessment, or integumentary interventions, or any goals related to wound. The physical therapy resumption</p> |               | <p>at some time during certification period starting February 15, 2015, but at the time of the survey visit this had been discontinued. b. Patient #3: This patient was discharged from the agency to hospice on March 27, 2015.</p> <p><b>Education:</b> a. Administrator or designee will educate all field staff clinicians (who perform wound care) regarding appropriate assessments to include but not limited to wound Management, wound Staging and Wound Documentation. 1. All professional staff to complete Gentiva University Courses: a. <i>About Wound Care: Identification andAssessment 1.5 Hours</i>. b. <i>Documenting wound care effectively .7 Hours</i> 2. All nurses will be signed off in practicum facilitated/supervised by administrator or designee utilizing wound mannequin. <b>Monitoring:</b> Administrator or designee will review 20 charts per week for 5 weeks starting April 20, 2015 for evidence of SN assessing patient's wounds per Gentiva policy and following physicianorders for wound care treatment/dressing changes. Once 95% compliance reached, monitoring willcontinue through quarterly clinical record review.</p> |                      |

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|                    | <p>of care on 2/14/15 failed to assess the surgical incision. The RN evaluation with skilled nursing visit dated 2/19/2015 failed to assess and document location, size, appearance or any description of the surgical incision. A Skilled visit note dated 2/24/15 also failed to evidence assessment of the surgical incision, stating, "No problems identified/skin intact."</p> <p>In a telephone interview with the patient's caregiver on March 24, 2015, at 4:00 PM, it was stated, " There was drainage from (The patients) left breast where a lump had been. The doctors drained some fluid on January 15th. They did surgery on it February 5th and then she went back into the hospital the following week with a urinary tract infection. The incision under the breast was about 3 or 4 inches. Its healed."</p> <p>3. Gentiva Health Services Policy, titled Wound Care 10-39 Revised 5/16/2012 states, . . . " Even though a wound may not require skilled nursing to perform the care, the wound may require skilled observation and evaluation for signs and symptom of infection or complications . . . "</p> <p>4. Gentiva Health Services Policy, titled, Assessment 03-05, Revised 10/23/2013</p> |               |   |                      |

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| N 546<br>Bldg. 00  | <p>states . . . " At least weekly, the wound(s) status will be observed and documented, including dimensions (L x W x D in cm), drainage amount and type, wound bed appearance and surrounding skin condition. Communication of any unexpected change in condition will be communicated promptly to members of the patient's care team."</p> <p>410 IAC 17-14-1(a)(1)(G)<br/>Scope of Services<br/>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:<br/>(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 interview and clinical record, agency document, and agency policy review, the registered nurse and agency failed to prepare clinical notes, including incident reports, fully describing and informing other personal in a change in a patient's condition (#10.)</p> <p>Findings include:</p> | N 546         | <b>N-0546 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</b> | 04/29/2015           |

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|                    | <p>1. In an interview with licensed practical nurse (LPN), Employee L, on March 26, 2015, at 5:00 PM, two wounds on patient number 10 lower left leg were described during a dressing change. The LPN stated, "The lower one is from tape removal and the upper one was an accident with scissors during a dressing change." The record failed to evidence the incident report was written timely.</p> <p>2. Clinical record #10 evidenced a communication note to physician dated 2/16/15 that stated, "Left VM [voicemail] at Westview wound clinic notifying them of the incident on 2/14/2015 with a skin tear on the medial shin d/t [due to] tape tore the skin as being pulled off . . . ."</p> <p>3. An agency document titled "Patient Events Reported for Cost Center '00058' between 01/01/2015 and 03/31/2015, evidenced an incident report was not filed until 3/26/2015.</p> <p>4. In an interview with a Branch Manager, on 3/30/15 at 6:00 PM, employee M states, "This patient has not had a major functional decline. ... The notes reflect that. We're taking care of the patient, the patient and the wound center are agreeable."</p> |               | <p><b>OTHER APPROPRIATE MEDICAL PERSONNEL OFCHANGED 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. Corrective Action:</b> a. Individual corrective counseling completed on March 26, 2015 with nurses who provided care to patient #10 on Gentiva policy for incident reporting. <b>Education:</b> a. The HHA management team will receive 1:1 education on thepolicy/process for completing Incident Reports. b. All clinical staff will complete: Gentiva University: <i>Incident Reporting Self-Paced Workbook</i>. c. Administrator or designee will educate all clinicians regarding Incident Reporting and Standards for Communication of the Change in Patient Condition. <b>Monitoring:</b> The administrator or designee will capture incident reports during morning stand-up calls. The Administrator or designee will also capture and review incidents during weekly location meetings. The administrator or designee will compare the meeting notes to the online incident reported every week for 5 weeks to ensure compliance. Once 95%</p> |                      |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE |
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| N 564<br>Bldg. 00  | <p>5. The undated Gentiva Policy 5-18 "Patient Incident Reporting and Sentinel Events" states, "All staff will report to the location, clinical manager or designee any unusual occurrence, variance in providing patient care, protects or services that result or could potentially result in injury or harm to the patient. Following receipt of the report, the location manager will promptly investigate and document all facts of the incident in the incident reporting system . . . Incidents will be reported to the location, clinical manager, or designee immediately after they occur. "</p> <p>410 IAC 17-14-1(c)(3)<br/>Scope of Services<br/>Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall:<br/>(3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function;</p> <p>Based on document review and interview, the agency failed to ensure the speech therapist accurately completed the patient's "Speech Therapist Plan of Care Worksheet" dated 3/9/15 for 1 of 1 record reviewed of patients receiving speech therapy. (#1)</p> <p>Findings include:</p> | N 564         | <p>compliance is achieved; further monitoring will be incorporated into the quarter advisory committee meetings QAC.</p> <p><b>N 564 410 IAC 17-14-1(C)(3) SCOPE OF SERVICES RULE 14 SEC 1C THE APPROPRIATE THERAPIST LISTED IN THE SUBSECTION (B) OF THIS RULE SHALL: (3) ASSIST THE PHYSICIAN, CHIROPRACTOR, PODIATRIST, DENTIST, OR OPTOMOTRIST IN EVALUATING LEVEL OF FUNCTION Corrective Action: a. Speech therapist</b></p> | 04/29/2015           |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157115 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/30/2015 |
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|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GENTIVA HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8606 ALLISONVILLE RD STE 350<br>INDIANAPOLIS, IN 46250 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|                    | <p>1. The "Speech Therapist Plan of Care Worksheet" dated 3/9/15 for patient #1 evidenced the therapist marked that the patient was a mechanical soft diet.</p> <p>2. On 3/25/15, the patient's spouse indicated the patient returned from a hospitalization right before the start of care on a regular diet.</p> |               | <p>educated pt#1 and family on diet ordered by physician on March 31, 2015. <b>Education:</b> a. Administrator or designee will complete 1:1 education to both speech therapists involved in the care of patient #1 regarding following physician orders in planof care. b. Administrator or designee will complete education to all Speech Therapists to review the terminology that is used in documentation regarding diet accurately reflects the ordered patient's diet based on standard definitions set by American Speech-Language-Hearing Association (ASHA)( i.e,regular, mechanical soft, purred etc.) <b>Monitoring:</b> Administrator or designee will review 5 charts per week for 5 weeks starting April 20, 2015 for evidence of completion and accuracy of diet section of Oasis document. Once 95% compliance reached, monitoring will continue through quarterly clinical record review.</p> |                      |