

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157553	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/26/2014
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NAME OF PROVIDER OR SUPPLIER  INDIANA HOMECARE NETWORK	STREET ADDRESS, CITY, STATE, ZIP CODE 3705 N BRIARWOOD LANE MUNCIE, IN 47304
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G000000	<p>This visit was a home health agency federal recertification survey. This was a partial extended survey.</p> <p>Survey dates: July 23, 24, 25, and 26, 2014</p> <p>Facility #: 003788</p> <p>Medicaid Vendor #: 200454290A</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Facility Census</p> <table> <tr> <td>Skilled Patients</td> <td>270</td> </tr> <tr> <td>Home Health Aide Only Patients</td> <td>6</td> </tr> <tr> <td>Personal Service Only Patients</td> <td>0</td> </tr> <tr> <td>Total</td> <td>276</td> </tr> </table> <p>Quality Review: Joyce Ellder, MSN, BSN, RN July 1, 2014</p>	Skilled Patients	270	Home Health Aide Only Patients	6	Personal Service Only Patients	0	Total	276	G000000	See each individual tag response.	
Skilled Patients	270											
Home Health Aide Only Patients	6											
Personal Service Only Patients	0											
Total	276											
G000121	<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. Based on observation, document review,</p>	G000121	The Director of Nursing/Director of Professional Services (DPS) or	07/07/2014								

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>and interview, the agency failed to ensure the home health aide (HHA) followed professional standards for bathing in 2 of 2 home visits with bathing with the potential to affect all patients receiving home health aide services. ( 3 &amp; 5 )</p> <p>Findings:</p> <p>1. On 6/24/14 at 2:00 PM, the home health aide, employee B, was observed giving a bath to patient # 3. The bath started in the bathroom with the patient sitting in the wheelchair. The patient agreed to a full bed bath and was moved to the bedroom. The patient had a large bowel movement earlier in the day and the caregiver had indicated the patient needed to be thoroughly cleaned. The aide changed the water after the upper bath. The aide then washed under the abdominal fold before washing the perineal area, instead of washing the perineal area first.</p> <p>2. On 6/25/14 at 8:00 AM, the home health aide, employee C, was observed giving a bath to patient # 5. The aide started with two tubs of water and washed the upper torso. The aide changed the water for the peri care. The aide then washed under the abdominal fold and then washed the perineal area instead of washing the perineal area first.</p>		<p>designee will inservice staff, including all home health aides/nurses regarding the practice to insure proper bathing techniques/sequencing of body areas. The training/inservice of staff will include review of the "Bathing Facts Sheet" which directs staff in the sequencing of the bathing process. Each staff member will complete a post-test following the training of patient bathing. Attendance at inservice training will be mandatory for home health aides. The DPS will be responsible for monitoring these corrective actions ensuring that the deficiency is corrected.</p> <p><b>Completion Date: 7/10/14</b></p> <p><b>Monitoring of compliance will be incorporated into the on-site observations of Home Health Aides (HHAs) every month for 3 months and then annually to be completed by the Clinical Manager and/or DPS. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</b></p>				

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G000144	<p>3. The Director of Nursing, employee D, attended all the home visits and indicated the aid should have washed the perineal area before washing under the abdominal fold.</p> <p>5. The website <a href="http://www.nursingassistanteducation.com">http://www.nursingassistanteducation.com</a> identifies how to give a bed bath and includes instructions on performing perineal care for men and women who do not have a perineal catheter. The instructions state, "Fill the bath basin with clean water at 110 degrees ... and wash, rinse and dry the rectal area." The instructions include specific instructions on how to wash the perineal area before the rectal area which are different for men and women.</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. Based on clinical record review and interview the agency failed to ensure effective communication occurred between their agency and another agency providing services within the same home in 1 of 6 homes visits with the potential to affect all 276 patients.</p>	G000144	The Director of Nursing will inservice all staff regarding the need for documentation of collaboration/coordination of care with other providers of services to patients. Applicable patients will have documentation included of this collaboration/coordination of	07/10/2014			

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G000158	<p>Findings:</p> <ol style="list-style-type: none"> <li>On 6/25/14 at 8 AM, during the 5th home visit, the patient indicated that a second home care agency was providing home services.</li> <li>On 6/26/14 at 3:25 PM, the Director of Nursing, employee D, indicated there was no communication with the other agency to make sure they complemented each other.</li> <li>Clinical record review 5, start of care 8/7/09, with physician orders for the certification period 5/13/14 through 7/11/14 for skilled nursing and home health aide services failed to evidence any communication between the two agencies.</li> </ol> <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. Based on clinical record review and interview, the agency failed to ensure care was provided as ordered on the plan of care for 5 of 12 clinical records reviewed with the potential to affect all</p>	G000158	<p>care at SOC and at least once during each episode of care. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. <b>Completion Date: 7/10/14</b> <b>Monitoring of compliance by the DPS/CLM will be completed through monthly review of all (100%) "Dual Services" patients for documentation of collaboration/coordination of care with other providers of services to the patient. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</b></p> <p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with physician orders was done at the 7/10/14 mandatory staff meeting.</p>	07/10/2014			

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	<p>276 patients. (2, 3, 7, 10, &amp; 12 )</p> <p>Findings:</p> <p>1. Clinical record 2, start of care (SOC) 4/12/14, included a plan of care for the certification period 4/12/14 through 6/10/14 with orders for skilled nursing for vancomycin (Vanco) administration via a picc line. A physician verbal order on 5/9/14 at 4:57 PM evidenced an order for the patient to continue IV Vanco times 1 week. The clinical record failed to evidence the Vanco was administered on 5/9/14. A physician verbal order on 5/14/14 at 11:58 AM evidenced an order for a physical therapy evaluation. The clinical record failed to evidence the physical therapist performed the evaluation.</p> <p>On 6/26/14 at 3 PM, the Director of Nursing, employee D, indicated the physical therapy evaluation had not been performed</p> <p>2. Clinical record 3, SOC 5/18/14, included a plan of care for the certification period 5/18/14 through 7/16/14 with orders for skilled nursing, home health aide, physical therapy and occupational therapy. The plan of care states, "Skilled nurse for administration and instruct / reinforce client / caregiver</p>		<p>Re-education including review of policies &amp; requirements as they relate to: plan of care and provision of care in accordance with physician orders. All staff will be re-educated in the principles of the following policy:</p> <p>·2.17 Plan of Care</p> <p>This re-education was completed by the Director of Nursing/Director of Professional Services (DPS). Monitoring of compliance will be incorporated into the quarterly on-site observations completed by the Clinical Manager and/or DPS. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p><b>Completion Date: 7/10/14.</b></p> <p><b>Monitoring of compliance of adherence with the Plan of Care is part of the "pre-billing audit" process conducted on each chart. Monitoring of "high risk" patient (i.e. Infusion, Wound) documentation will be performed by the DPS/CLM monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</b></p>				

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	<p>teaching of wound care. Right 5th toe and left lower leg cleanse with wound wash or normal saline. apply mupirocin. cover with Band-Aid using clean technique. To be completed daily by pt (patient)/cg (caregiver)/sn (skilled nurse). Facial wounds: cleanse with antibacterial soap and water. Apply mupirocin using clean technique. To be completed TID (three times a day) by pt/cg/sn. Tracheal stoma site wound: cleanse with peroxide, rinse with saline and apply Mupirocin using clean technique. To be completed daily by pt/cg/sn." The clinical record failed to evidence wound care had been provided on 5/24/14.</p> <p>On 6/26/14 at 2:40 PM, the Director of Nursing, employee D indicated the wound care had not been performed.</p> <p>3. Clinical record 7, SOC 3/25/14, included a plan of care for the certification period 5/24/14 through 7/22/14 with orders for skilled nursing, home health aide 2 times a week times 8 weeks then 1 time a week times 1 week, and physical therapy and occupational therapy evaluation. The clinical record failed to evidence the physical therapy evaluation had been performed and that two home health aide visits had been made the second week.</p>			

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	<p>On 6/26/14 at 4:10 PM, the Director of Nursing, employee D indicated the home health aide had missed the visit and the physical therapy evaluation had not been performed.</p> <p>4. Clinical record 10, SOC 1/25/14, included a plan of care for the certification period 1/25/14 through 3/25/14 with orders for skilled nursing 1 time a week times 1 week then 3 times a week times 4 weeks then 1 times a week times 3 weeks, home health aide, physical therapy and occupational therapy. The plan of care states, "Skilled nurse for administration and instruct / reinforce client / caregiver teaching of surgical incision care cleanse RUQ [right upper quadrant] and LUQ [left upper quadrant] incision with soap and water or wound wash. Apply skin prep to peri wound. Cover with using bordered gauze using clean technique daily. CG to perform on non nurse days." Clinical record failed to evidence wound care had been performed on 1/27/14, 1/28/14, 1/31/14, 2/3/14, 2/4/14, 2/6/14, 2/10/14, 2/13/14, 2/17/14, 2/20/14, 2/24/14, 2/27/14, 3/6/14 and 3/13/14.</p> <p>On 6/26/14 at 3:05 PM, the Director of Nursing, employee D indicated the wound care had not been performed as ordered.</p>				

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G000170	<p>5. Clinical record 12, SOC 9/28/13, included a plan of care for the certification period 11/27/13 through 1/25/14 with orders for skilled nursing, home health aide, and physical therapy evaluation. The record failed to evidence the physical therapy evaluation had been completed</p> <p>On 6/26/14 at 2:00 PM the director of Nursing, employee D, indicated the physical therapy evaluation had not been performed.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review and interview, the agency failed to ensure the registered nurse provided care as the plan of care was written for 3 of 12 clinical records reviewed with the potential to affect all 276 patients. (2, 3, 10 )</p>	G000170	<p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with physician orders was done at the 7/10/14 mandatory staff meeting. Re-education including review of</p>	07/10/2014

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	<p>Findings:</p> <p>1. Clinical record 2, start of care (SOC) 4/12/14, included a plan of care for the certification period 4/12/14 through 6/10/14 with orders for skilled nursing for vancomycin (Vanco) administration via a picc line. A physician verbal order on 5/9/14 at 4:57 PM evidenced an order for the patient to continue IV Vanco times 1 week. The clinical record failed to evidence the Vanco was administered on 5/9/14.</p> <p>2. Clinical record 3, SOC 5/18/14, included a plan of care for the certification period 5/18/14 through 7/16/14 with orders for skilled nursing, home health aide, physical therapy and occupational therapy. The plan of care states, "Skilled nurse for administration and instruct / reinforce client / caregiver teaching of wound care. Right 5th toe and left lower leg cleanse with wound wash or normal saline. apply mupirocin. cover with Band-Aid using clean technique. To be completed daily by pt (patient)/cg (caregiver)/sn (skilled nurse). Facial wounds: cleanse with antibacterial soap and water. Apply mupirocin using clean technique. To be completed TID (three times a day) by pt/cg/sn. Tracheal stoma site wound: cleanse with peroxide,</p>		<p>policies &amp; requirements as they relate to: plan of care and provision of care in accordance with physician orders. All staff will be re-educated in the principles of the following policy:</p> <p>·2.17 Plan of Care This re-education was completed by the Director of Nursing/Director of Professional Services (DPS). Monitoring of compliance will be incorporated into the quarterly on-site observations completed by the Clinical Manager and/or DPS. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p><b>Completion Date: 7/10/14.</b> <b>Monitoring of compliance of adherence with the Plan of Care is part of the "pre-billing audit" process conducted on each chart. Monitoring of "high risk" patient (i.e. Infusion, Wound) documentation will be performed by the DPS/CLM monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</b></p>				

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	<p>rinse with saline and apply Mupirocin using clean technique. To be completed daily by pt/cg/sn." The clinical record failed to evidence wound care had been provided on 5/24/14.</p> <p>On 6/26/14 at 2:40 PM, the Director of Nursing, employee D indicated the wound care had not been performed.</p> <p>3. Clinical record 10, SOC 1/25/14, included a plan of care for the certification period 1/25/14 through 3/25/14 with orders for skilled nursing 1 time a week times 1 week then 3 times a week times 4 weeks then 1 times a week times 3 weeks, home health aide, physical therapy and occupational therapy. The plan of care states, "Skilled nurse for administration and instruct / reinforce client / caregiver teaching of surgical incision care cleanse RUQ [right upper quadrant] and LUQ [left upper quadrant] incision with soap and water or wound wash. Apply skin prep to peri wound. Cover with using bordered gauze using clean technique daily. CG to perform on non nurse days." Clinical record failed to evidence wound care had been performed on 1/27/14, 1/28/14, 1/31/14, 2/3/14, 2/4/14, 2/6/14, 2/10/14, 2/13/14, 2/17/14, 2/20/14, 2/24/14, 2/27/14, 3/6/14 and 3/13/14.</p>						

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G000185	<p>On 6/26/14 at 3:05 PM, the Director of Nursing, employee D indicated the wound care had not been performed as ordered.</p> <p>484.32 THERAPY SERVICES Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the physical therapist provided care as ordered on the plan of care for 3 of 6 records reviewed with physical therapy ordered with the potential to affect all patients who receive physical therapy services. (2, 7 &amp; 12 )</p> <p>Findings:</p> <p>1. Clinical record 2, start of care (SOC) 4/12/14, included a plan of care for the certification period 4/12/14 through 6/10/14 with orders for skilled nursing for vancomycin (Vanco) administration</p>	G000185	<p>Re-education with all therapy staff regarding expectations as they relate to provision of care in accordance with physician orders was done at the 7/10/14 mandatory staff meeting.</p> <p>Re-education including review of policies &amp; requirements as they relate to: plan of care and provision of care in accordance with physician orders. All staff will be re-educated in the principles of the following policy:</p> <p>·2.17 Plan of Care</p> <p>This re-education was completed by the Director of Nursing/Director of Professional Services (DPS) and the Director of Rehabilitation Services. Monitoring of compliance will be incorporated into the quarterly</p>	07/10/2014

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	<p>via a picc line. A physician verbal order on 5/14/14 at 11:58 AM evidenced an order for a physical therapy evaluation. The clinical record failed to evidence the physical therapist performed the evaluation.</p> <p>On 6/26/14 at 3 PM, the Director of Nursing, employee D, indicated the physical therapy evaluation had not been performed.</p> <p>2. Clinical record 7, SOC 3/25/14, included a plan of care for the certification period 5/24/14 through 7/22/14 with orders for skilled nursing, home health aide 2 times a week times 8 weeks then 1 time a week times 1 week, and physical therapy and occupational therapy evaluations. The clinical record failed to evidence the physical therapy evaluation had been performed.</p> <p>On 6/26/14 at 4:10 PM, the Director of Nursing, employee D indicated the physical therapy evaluation had not been performed.</p> <p>3. Clinical record 12, SOC 9/28/13 with physician orders for the certification period 11/27/13 through 1/25/14 for skilled nursing, home health aide and physical therapy evaluation. The record failed to evidence the physical therapy</p>		<p>on-site observations completed by the Director of Rehabilitation Services and/or DPS. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p><b>Completion Date: 7/10/14.</b></p> <p><b>Monitoring of compliance of adherence with the Plan of Care is part of the "pre-billing audit" process conducted on each chart.</b></p> <p><b>Monitoring of "high risk" patient (i.e. Infusion, Wound) documentation will be performed by the DPS/CLM monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</b></p>		

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G000186	<p>evaluation had been completed</p> <p>On 6/26/14 at 2:00 PM the director of Nursing, employee D, indicated the physical therapy evaluation had not been performed.</p> <p>484.32 THERAPY SERVICES 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 clinical record review and interview, the agency failed to ensure the therapist completed the evaluation timely in 1 of 12 clinical records reviewed with the potential to affect all therapy patients.</p> <p>Findings</p> <p>1. Clinical record 6, start of care 4/29/14, evidenced physician orders for the certification period 4/29/14 through 6/27/14 for skilled nursing, home health aide, physical therapy evaluation, occupational therapy evaluation and</p>	G000186	<p>Re-education with all therapy staff regarding expectations as they relate to provision of care in accordance with physician orders, including expectation of timely evaluation visits was done at the 7/10/14 mandatory staff meeting.</p> <p>Re-education including review of policies &amp; requirements as they relate to: plan of care and provision of care in accordance with physician orders. All staff will be re-educated in the principles of the following policy: -2.17 Plan of Care</p> <p>This re-education was completed by the Director of Nursing/Director of Professional Services (DPS) and the Director</p>	07/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157553	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/26/2014
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N000000	<p>speech therapy evaluation. The clinical record evidenced on a "Client Coordination Note Report" a missed visit by the speech therapist that states, "Unable to see patient secondary to time constraints." The speech therapy evaluation was not completed until 5/13/14.</p> <p>The clinical record evidenced the patients diagnosis as aftercare surgery oral cavity and dysphasia, unspecified.</p> <p>2. On 6/26/14 at 3:30 PM, the Director of Nursing, employee D, indicated the evaluation was not done till 5/13/14, day 14 and that was too late.</p> <p>This visit was a home health agency state relicensure survey.</p> <p>Survey dates: July 23, 24, 25, and 26, 2014</p> <p>Facility #: 003788</p> <p>Medicaid Vendor #: 200454290A</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p>	N000000	<p>of Rehabilitation Services. 10% of therapy evaluation documents will be reviewed monthly x 3 months for timely completion of evaluation by the Director of Rehabilitation Services and/or DPS. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p><b>Completion Date: 7/10/14. Monitoring of compliance of timely completion of therapy evaluation will be completed with monthly review of 10 charts or 10% of evaluations (whichever is greater) by the Director of Rehabilitation Services and/or DPS. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</b></p> <p>See each individual tag response.</p>	

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N000486	<p>Facility Census</p> <table> <tr> <td>Skilled Patients</td> <td>270</td> </tr> <tr> <td>Home Health Aide Only Patients</td> <td>6</td> </tr> <tr> <td>Personal Service Only Patients</td> <td>0</td> </tr> <tr> <td>Total</td> <td>276</td> </tr> </table> <p>Quality Review: Joyce Ellder, MSN, BSN, RN July 1, 2014</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record review and interview the agency failed to ensure effective communication occurred between their agency and another agency providing services within the same home in 1 of 6 homes visits with the potential to affect all 276 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 6/25/14 at 8 AM, during the 5th home visit, the patient indicated that a second home care agency was providing home services.</li> <li>On 6/26/14 at 3:25 PM, the Director of Nursing, employee D, indicated there</li> </ol>	Skilled Patients	270	Home Health Aide Only Patients	6	Personal Service Only Patients	0	Total	276	N000486	<p>The Director of Nursing will inservice all staff regarding the need for documentation of collaboration/coordination of care with other providers of services to patients. Applicable patients will have documentation included of this collaboration/coordination of care at SOC and at least once during each episode of care. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p><b>Completion Date: 7/10/14</b> <b>Monitoring of compliance by the DPS/CLM will be completed through monthly review of all (100%) "Dual Services" patients for documentation of collaboration/coordination of care</b></p>	07/10/2014
Skilled Patients	270											
Home Health Aide Only Patients	6											
Personal Service Only Patients	0											
Total	276											

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N000522	<p>was no communication with the other agency to make sure they complemented each other.</p> <p>3. Clinical record review 5, start of care 8/7/09, with physician orders for the certification period 5/13/14 through 7/11/14 for skilled nursing and home health aide services failed to evidence any communication between the two agencies.</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 review and interview, the agency failed to ensure care was provided as ordered on the plan of care for 5 of 12 clinical records reviewed with the potential to affect all 276 patients. (2, 3, 7, 10, &amp; 12 )</p> <p>Findings:</p> <p>1. Clinical record 2, start of care (SOC) 4/12/14, included a plan of care for the certification period 4/12/14 through 6/10/14 with orders for skilled nursing for vancomycin (Vanco) administration via a picc line. A physician verbal order on 5/9/14 at 4:57 PM evidenced an order</p>	N000522	<p><b>with other providers of services to the patient. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</b></p> <p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with physician orders was done at the 7/10/14 mandatory staff meeting. Re-education including review of policies &amp; requirements as they relate to: plan of care and provision of care in accordance with physician orders. All staff will be re-educated in the principles of the following policy: ·2.17 Plan of Care This re-education was completed by the Director of Nursing/Director of Professional Services (DPS). Monitoring of compliance will be incorporated into the quarterly on-site observations completed by the</p>	07/10/2014			

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	<p>for the patient to continue IV Vanco times 1 week. The clinical record failed to evidence the Vanco was administered on 5/9/14. A physician verbal order on 5/14/14 at 11:58 AM evidenced an order for a physical therapy evaluation. The clinical record failed to evidence the physical therapist performed the evaluation.</p> <p>On 6/26/14 at 3 PM, the Director of Nursing, employee D, indicated the physical therapy evaluation had not been performed</p> <p>2. Clinical record 3, SOC 5/18/14, included a plan of care for the certification period 5/18/14 through 7/16/14 with orders for skilled nursing, home health aide, physical therapy and occupational therapy. The plan of care states, "Skilled nurse for administration and instruct / reinforce client / caregiver teaching of wound care. Right 5th toe and left lower leg cleanse with wound wash or normal saline. apply mupirocin. cover with Band-Aid using clean technique. To be completed daily by pt (patient)/cg (caregiver)/sn (skilled nurse). Facial wounds: cleanse with antibacterial soap and water. Apply mupirocin using clean technique. To be completed TID (three times a day) by pt/cg/sn. Tracheal stoma site wound: cleanse with peroxide,</p>		<p>Clinical Manager and/or DPS. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p><b>Completion Date: 7/10/14.</b></p> <p>Monitoring of compliance of adherence with the Plan of Care is part of the "pre-billing audit" process conducted on each chart. Monitoring of "high risk" patient (i.e. Infusion, Wound) documentation will be performed by the DPS/CLM monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p>				

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	<p>rinse with saline and apply Mupirocin using clean technique. To be completed daily by pt/cg/sn." The clinical record failed to evidence wound care had been provided on 5/24/14.</p> <p>On 6/26/14 at 2:40 PM, the Director of Nursing, employee D indicated the wound care had not been performed.</p> <p>3. Clinical record 7, SOC 3/25/14, included a plan of care for the certification period 5/24/14 through 7/22/14 with orders for skilled nursing, home health aide 2 times a week times 8 weeks then 1 time a week times 1 week, and physical therapy and occupational therapy evaluation. The clinical record failed to evidence the physical therapy evaluation had been performed and that two home health aide visits had been made the second week.</p> <p>On 6/26/14 at 4:10 PM, the Director of Nursing, employee D indicated the home health aide had missed the visit and the physical therapy evaluation had not been performed.</p> <p>4. Clinical record 10, SOC 1/25/14, included a plan of care for the certification period 1/25/14 through 3/25/14 with orders for skilled nursing 1 time a week times 1 week then 3 times a</p>				

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	<p>week times 4 weeks then 1 times a week times 3 weeks, home health aide, physical therapy and occupational therapy. The plan of care states, "Skilled nurse for administration and instruct / reinforce client / caregiver teaching of surgical incision care cleanse RUQ [right upper quadrant] and LUQ [left upper quadrant] incision with soap and water or wound wash. Apply skin prep to peri wound. Cover with using bordered gauze using clean technique daily. CG to perform on non nurse days." Clinical record failed to evidence wound care had been performed on 1/27/14, 1/28/14, 1/31/14, 2/3/14, 2/4/14, 2/6/14, 2/10/14, 2/13/14, 2/17/14, 2/20/14, 2/24/14, 2/27/14, 3/6/14 and 3/13/14.</p> <p>On 6/26/14 at 3:05 PM, the Director of Nursing, employee D indicated the wound care had not been performed as ordered.</p> <p>5. Clinical record 12, SOC 9/28/13, included a plan of care for the certification period 11/27/13 through 1/25/14 with orders for skilled nursing, home health aide, and physical therapy evaluation. The record failed to evidence the physical therapy evaluation had been completed</p> <p>On 6/26/14 at 2:00 PM the director of</p>			

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N000537	<p>Nursing, employee D, indicated the physical therapy evaluation had not been performed.</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 the registered nurse provided care as the plan of care was written for 3 of 12 clinical records reviewed with the potential to affect all 276 patients. (2, 3, 10 )</p> <p>Findings:</p> <p>1. Clinical record 2, start of care (SOC) 4/12/14, included a plan of care for the certification period 4/12/14 through 6/10/14 with orders for skilled nursing for vancomycin (Vanco) administration via a picc line. A physician verbal order on 5/9/14 at 4:57 PM evidenced an order for the patient to continue IV Vanco times 1 week. The clinical record failed to evidence the Vanco was administered on 5/9/14.</p> <p>2. Clinical record 3, SOC 5/18/14, included a plan of care for the certification period 5/18/14 through</p>	N000537	<p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with physician orders was done at the 7/10/14 mandatory staff meeting. Re-education including review of policies &amp; requirements as they relate to: plan of care and provision of care in accordance with physician orders. All staff will be re-educated in the principles of the following policy: ·2.17 Plan of Care This re-education was completed by the Director of Nursing/Director of Professional Services (DPS). Monitoring of compliance will be incorporated into the quarterly on-site observations completed by the Clinical Manager and/or DPS. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. <b>Completion Date: 7/10/14.</b> <b>Monitoring of compliance of adherence with the Plan of Care is</b></p>	07/10/2014			

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	<p>7/16/14 with orders for skilled nursing, home health aide, physical therapy and occupational therapy. The plan of care states, "Skilled nurse for administration and instruct / reinforce client / caregiver teaching of wound care. Right 5th toe and left lower leg cleanse with wound wash or normal saline. apply mupirocin. cover with Band-Aid using clean technique. To be completed daily by pt (patient)/cg (caregiver)/sn (skilled nurse). Facial wounds: cleanse with antibacterial soap and water. Apply mupirocin using clean technique. To be completed TID (three times a day) by pt/cg/sn. Tracheal stoma site wound: cleanse with peroxide, rinse with saline and apply Mupirocin using clean technique. To be completed daily by pt/cg/sn." The clinical record failed to evidence wound care had been provided on 5/24/14.</p> <p>On 6/26/14 at 2:40 PM, the Director of Nursing, employee D indicated the wound care had not been performed.</p> <p>3. Clinical record 10, SOC 1/25/14, included a plan of care for the certification period 1/25/14 through 3/25/14 with orders for skilled nursing 1 time a week times 1 week then 3 times a week times 4 weeks then 1 times a week times 3 weeks, home health aide, physical therapy and occupational</p>		<p>part of the "pre-billing audit" process conducted on each chart. Monitoring of "high risk" patient (i.e. Infusion, Wound) documentation will be performed by the DPS/CLM monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p>				

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N000564	<p>therapy. The plan of care states, "Skilled nurse for administration and instruct / reinforce client / caregiver teaching of surgical incision care cleanse RUQ [right upper quadrant] and LUQ [left upper quadrant] incision with soap and water or wound wash. Apply skin prep to peri wound. Cover with using bordered gauze using clean technique daily. CG to perform on non nurse days." Clinical record failed to evidence wound care had been performed on 1/27/14, 1/28/14, 1/31/14, 2/3/14, 2/4/14, 2/6/14, 2/10/14, 2/13/14, 2/17/14, 2/20/14, 2/24/14, 2/27/14, 3/6/14 and 3/13/14.</p> <p>On 6/26/14 at 3:05 PM, the Director of Nursing, employee D indicated the wound care had not been performed as ordered.</p> <p>410 IAC 17-14-1(c)(3) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function;</p> <p>Based on clinical record review and interview, the agency failed to ensure the physical therapist provided care as ordered on the plan of care for 3 of 6 records reviewed with physical therapy</p>	N000564	Re-education with all therapy staff regarding expectations as they relate to provision of care in accordance with physician orders was done at the 7/10/14 mandatory staff meeting. Re-education including review of policies & requirements as they relate to: plan of care and	07/10/2014

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	<p>ordered with the potential to affect all patients who receive physical therapy services. (2, 7 &amp; 12 )</p> <p>Findings:</p> <p>1. Clinical record 2, start of care (SOC) 4/12/14, included a plan of care for the certification period 4/12/14 through 6/10/14 with orders for skilled nursing for vancomycin (Vanco) administration via a picc line. A physician verbal order on 5/14/14 at 11:58 AM evidenced an order for a physical therapy evaluation. The clinical record failed to evidence the physical therapist performed the evaluation.</p> <p>On 6/26/14 at 3 PM, the Director of Nursing, employee D, indicated the physical therapy evaluation had not been performed.</p> <p>2. Clinical record 7, SOC 3/25/14, included a plan of care for the certification period 5/24/14 through 7/22/14 with orders for skilled nursing, home health aide 2 times a week times 8 weeks then 1 time a week times 1 week, and physical therapy and occupational therapy evaluations. The clinical record failed to evidence the physical therapy evaluation had been performed.</p>		<p>provision of care in accordance with physician orders. All staff will be re-educated in the principles of the following policy: ·2.17 Plan of Care This re-education was completed by the Director of Nursing/Director of Professional Services (DPS) and the Director of Rehabilitation Services. Monitoring of compliance will be incorporated into the quarterly on-site observations completed by the Director of Rehabilitation Services and/or DPS. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. <b>Completion Date: 7/10/14.</b> <b>Monitoring of compliance of adherence with the Plan of Care is part of the "pre-billing audit" process conducted on each chart.</b> <b>Monitoring of "high risk" patient (i.e. Infusion, Wound) documentation will be performed by the DPS/CLM monthly as part of the quarterly 10% Performance Improvement chart audit. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</b></p>				

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	<p>On 6/26/14 at 4:10 PM, the Director of Nursing, employee D indicated the physical therapy evaluation had not been performed.</p> <p>3. Clinical record 12, SOC 9/28/13 with physician orders for the certification period 11/27/13 through 1/25/14 for skilled nursing, home health aide and physical therapy evaluation. The record failed to evidence the physical therapy evaluation had been completed</p> <p>On 6/26/14 at 2:00 PM the director of Nursing, employee D, indicated the physical therapy evaluation had not been performed.</p>						