

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 W LINCOLN HWY MERRILLVILLE, IN 46410
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G000000	<p>This visit was a home health federal recertification survey. This was a partial extended survey.</p> <p>Survey dates: 9/17/14 to 9/19/14</p> <p>Facility #: 003074</p> <p>Medicaid Vendor #: 200399420</p> <p>Surveyor: Tonya Tucker, RN, PHNS and Ingrid Miller, RN, PHNS</p> <p>Census: 91</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 25, 2014</p>	G000000		
G000303	<p>484.48 CLINICAL RECORDS The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge.</p> <p>Based on clinical record review, agency</p>	G000303	The Nursing Supervisor has inserviced nursing and office staff that the discharge summary to include the patient's medical and	09/29/2014

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>policy review, and interview, the agency failed to ensure the physician was notified of a patient discharge and the record contained a discharge summary in 1 of 2 discharged records reviewed. (#8)</p> <p>Findings include:</p> <p>1. Clinical record #8, discharge date 5/11/14, failed to evidence the physician was notified of patient discharge from services and a discharge summary.</p> <p>A. The record evidenced a document signed by employee F (registered nurse), dated 5/11/14, titled "Transfer To An Inpatient Facility Assessment (06): OASIS C" that stated, "" (M0906 Discharge/Transfer/Death Date: ... '05/11/2014' 'Late entry 5/16/14 3:00 PM [family member] reports that patient will go to hospice following discharge from hospital. - [employee F]."</p> <p>B. On 9/19/14 at 11:06 AM, employee A (administrator) indicated being unable to locate documentation to support the physician was notified of the patient discharge from agency service or a discharge summary.</p> <p>3. The undated agency policy titled "CATEGORY: Provision of care and record management SUBJECT:</p>		<p>health status and must be sent to the attending physician upon discharged. Discharge summary sent to attending physician will have a documentation to support that the physician was notified. 100% of all discharged clinical records will be audited concurrently for evidence that a discharge summary for each patient was sent to the attending physician. The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that discharged summary is sent and will not recur.</p>	

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G000337	<p>Additional clinical record components STANDARD: HH5-1A.01" states, "Policy: Additional clinical record components: ... E. Utilizing the appropriate Oasis assessment discharge form (06,08,09), the discharge summary will be completed by appropriate staff members ... at the time of discharge. When a patient is discharged and the discharge summary is completed, the d/c [discharge] summary is reviewed and co-signed by the nursing supervisor or her designee for accuracy, completeness ... A copy of the discharge summary will be sent to the physician ... The discharge summary includes, but is not limited to, the following information: ... 6. timely notification of discharge to patient, family, and physician documented. ... ."</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review and interview, the agency failed to ensure the drug regimen was reviewed for every patient with recertification assessments</p>	G000337	The Nursing Supervisor has inserviced nursing staff that the drug regimen must be reviewed for every patient with recertification assessments and as needed in order to identify any potential adverse effects and drug reactions, significant side effects, ineffective drug	09/29/2014

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N000000	<p>for 1 of 10 active patient records reviewed creating the potential to affect all patients of the agency. (#5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #5, start of care date 6/18/14, contained a plan of care for certification period 8/17 to 10/15/14. The record contained a document titled "Medication Listing" with an initial reviewed date as 6/18/14 by the registered nurse. The record failed to evidence the medication profile was reviewed and updated for the new recertification period.</li> <li>On 9/17/14 at 2:06 PM, employee A (administrator) indicated the medication list should have been reviewed and updated by the registered nurse for the new recertification period.</li> </ol> <p>This visit was a home health state relicensure survey.</p> <p>Survey Dates: 9/17/14 to 9/19/14</p> <p>Facility #: 003074</p>	N000000	<p>therapy, significant drug interactions, duplicate drug therapy and non-compliance with drug therapy. 100% of all clinical records will be audited for every patient with recertification assessments concurrently for evidence that the drug regimen was reviewed for every patient. The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that drug regimen will be reviewed and will not recur.</p>				

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N000608	<p>Medicaid Vendor #: 200399420</p> <p>Surveyor: Tonya Tucker, RN, PHNS and Ingrid Miller, RN, PHNS</p> <p>Census: 91</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 25, 2014</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on clinical record review, agency policy review, and interview, the agency failed to ensure the physician was notified of a patient discharge and the</p>	N000608	The Nursing Supervisor has inserviced nursing and office staff that the discharge summary to include the patient's medical and health status and must be sent to the attending physician upon	09/29/2014

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	<p>record contained a discharge summary in 1 of 2 discharged records reviewed. (#8)</p> <p>Findings include:</p> <p>1. Clinical record #8, discharge date 5/11/14, failed to evidence the physician was notified of patient discharge from services and a discharge summary.</p> <p>A. The record evidenced a document signed by employee F (registered nurse), dated 5/11/14, titled "Transfer To An Inpatient Facility Assessment (06): OASIS C" that stated, "" (M0906 Discharge/Transfer/Death Date: ... '05/11/2014' 'Late entry 5/16/14 3:00 PM [family member] reports that patient will go to hospice following discharge from hospital. - [employee F].""</p> <p>B. On 9/19/14 at 11:06 AM, employee A (administrator) indicated being unable to locate documentation to support the physician was notified of the patient discharge from agency service or a discharge summary.</p> <p>3. The undated agency policy titled "CATEGORY: Provision of care and record management SUBJECT: Additional clinical record components STANDARD: HH5-1A.01" states, "Policy: Additional clinical record</p>		<p>discharged. Discharge summary sent to attending physician will have a documentation to support that the physician was notified. 100% of all discharged clinical records will be audited concurrently for evidence that a discharge summary for each patient was sent to the attending physician. The Nursing Supervisor will be responsible for monitoring these corrective actions to ensure that discharged summary is sent and will not recur.</p>				

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	<p>components: ... E. Utilizing the appropriate Oasis assessment discharge form (06,08,09), the discharge summary will be completed by appropriate staff members ... at the time of discharge. When a patient is discharged and the discharge summary is completed, the d/c [discharge] summary is reviewed and co-signed by the nursing supervisor or her designee for accuracy, completeness ... A copy of the discharge summary will be sent to the physician ... The discharge summary includes, but is not limited to, the following information: ... 6. timely notification of discharge to patient, family, and physician documented. ... ."</p>				