

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157143	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER MARGARET MARY COMMUNITY HOSPITAL HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 108 N ELM BATESVILLE, IN 47006
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G0000	<p>This visit was for a home health federal recertification survey. This was a partial extended survey.</p> <p>Survey dates: 5/14-17/12</p> <p>Facility #005320</p> <p>Medicaid #100264100A</p> <p>Survey Team: Dawn Snider, RN, PHNS</p> <p>Census Service Type:</p> <p>Skilled Patients: 718 Home Health Aide Only Patients: 3 Personal Service Only Patients: 1 Total: 722</p> <p>Sample:</p> <p>RR w HV: 6 RR w/o HV: 6</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 25, 2012</p>	G0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on observation, interview, and clinical record and agency policy review, the agency failed to ensure all patients had an individualized plan of care that included all of the required elements for 11 of 12 (#1,#2, #3, #4, #6, #7, #8, #9, #10, #11 and #12) active clinical records reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1 included a plan of care for the certification period of 4/10/12-6/8/12 that failed to evidence the patient had a wheelchair, rolling walker, 2 regular walkers, bedside commode, lift chair, hospital bed, overbed table, and tub shower bench. These items were observed in the patient's on 5/15/12 at 3:05 PM. 2. Clinical record #2 included a plan of 	G0159	The Director will have a staff meeting with all home health clinicians to inservice them on including all DME in the patient's home on the plan of care. This inservice will be reflected in the minutes of the meeting. To prevent deficiency from recurring the QA/PI Coordinator (the nurse who audits all admissions, recerts, resumps) will review the plan of care with the assessing clinician to ensure all equipment is listed on the plan of care. The QA/PI Coordinator will maintain a record of all charts reviewed beginning June 7, 2012 and ending June 17, 2012 and indicate if all DME is recorded on the plan of care. The QA/PI Coordinator will be responsible for the audit. If more than 2 plans of care are out of compliance, the audit will continue for 30 more days and will be in full compliance by July 17, 2012. The inservice will be held on June 7, 2012. All DME will be recorded on the plan of care performed by June 17,	06/17/2012			

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	<p>care for the certification period of 5/10/12-7/8/12 that failed to evidence the patient had a straight cane and shower bench. These items were observed in the patient's home on 5/15/12 at 12: 25 PM.</p> <p>3. Clinical record #3 included a plan of care for the certification period of 5/6/12-7/4/12 that failed to evidence the patient had a straight cane. This item was observed in the patient's home on 5/15/12 at 12:05 PM.</p> <p>4. Clinical record #4 included a plan of care for the certification period of 5/12/12-7/10/12 that failed to evidence the patient had a knee/flexor machine, and a post operative knee brace. These items were observed in the patient's home on 5/15/12 at 5:55 PM.</p> <p>5. Clinical record #6 included a plan of care for the certification period of 5/2/12-6/30/12 that failed to evidence a straight cane and central dressing line supplies. These items were observed in the patient's home on 5/16/2012 at 10:35 AM.</p> <p>6. Clinical record #7 included a physical therapy assistant note dated 5/14/12 that identified the patient had a rolling walker. The plan of care for the certification period of 4/28/12-6/26/12 failed to</p>		2012The Director will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.		

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	<p>evidence a rolling walker.</p> <p>7. Clinical record #8 included a physical therapy note dated 4/25/12 that identified the patient had a walker, bed side commode, and wheelchair. The plan of care for the certification period of 4/3/12-6/1/12 failed to evidence a walker, bedside commode, and wheel chair.</p> <p>8. Clinical record #9 included a physical therapy note dated 5/11/12 that identified the patient had a walker. The plan of care for the certification period of 4/21/12-6/19/12 failed to evidence a walker.</p> <p>9. Clinical record #10 included an occupational therapy note dated 4/25/12 that identified the patient had walker. A physical therapy note dated 4/11/12 identified the patient uses oxygen. The plan of care for the certification period of 3/25/12-5/23/12 failed to evidence a walker and oxygen.</p> <p>10. Clinical record #11 included a physical therapy note dated 5/14/12 that identified the patient had a walker and cane. The plan of care for the certification period of 5/11/12-7/9/12 failed to evidence a walker and cane.</p> <p>11. Clinical record #12 included a skilled</p>						

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	<p>nurse note dated 4/11/12 that identified the patient had oxygen. The plan of care for the certification period of 4/17/12-6/15/12 failed to evidence oxygen.</p> <p>12. On 5/15/2012 at 5/15/12 at 11:00 AM the manager, employee X, indicated no durable medical equipment would be on the plans of care because of a concern regarding Medicare billing since another vendor supplied the durable medical equipment.</p> <p>13. The agency policy revised date 7/19/02 and titled "Plan of Treatment" states, "At a minimum the plan of treatment must cover pertinent diagnoses,... types of services and equipment required ..."</p>			

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G0176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review, interview, and policy review the agency failed to inform the physician of a change in the patient's needs for 1 of 12 clinical records reviewed (#10) with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #10, start of care 3/25/2012, evidenced the patient received occupational therapy (O.T.) services on 5/2, 5/4, 5/9/12 and was discharged from occupational therapy services on 5/14/12 without a physician's order. 2. On 5/16/2012 at 4:45 PM, the manager of the agency, employee X, indicated there were no O.T. orders for the patient. 3. The policy with a revised date of 7/19/02 titled "Plan of Care" states, "The physician is promptly alerted to any changes that suggest a need to alter the plan. The physician is consulted to approve additions or modifications to the original plan. Care must be rendered in conformance with each order on the plan of treatment. Any change of orders 	G0176	<p>The deficiency occurred when the OT indicated accidentally in the computer system that the order did not need to go to the physician for signature. The initial order had been written on 5/2/12. On 5/18/12 the OT corrected the error in the computer system so the order would print. The order was then sent to the physician for signature and returned signed to the agency on 5/22/12. The OT was re-instructed in the correct procedures for physician orders to be denoted for printing for physician signature. The QA/PI Coordinator will monitor for accuracy of physician orders which she currently does in the normal course of her duties. The Director will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.</p>	05/18/2012			

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	required while the plan is in effect can be made by writing a change of order and obtaining the physician's signature for the order."				

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on observation, interview, and clinical record and agency policy review, the agency failed to ensure all patients had an individualized plan of care that included all of the required elements for 11 of 12 (#1,#2, #3, #4, #6, #7, #8, #9, #10, #11 and #12) active clinical records reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p>	N0524	The Director will have a staff meeting with all home health clinicians to inservice them on including all DME in the patient's home on the plan of care. This inservice will be reflected in the minutes of the meeting. To prevent deficiency from recurring the QA/PI Coordinator (the nurse who audits all admissions, recerts, resumps) will review the plan of care with the assessing clinician to ensure all equipment is listed on the plan of care. The QA/PI Coordinator will maintain a	06/17/2012			

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	<p>1. Clinical record #1 included a plan of care for the certification period of 4/10/12-6/8/12 that failed to evidence the patient had a wheelchair, rolling walker, 2 regular walkers, bedside commode, lift chair, hospital bed, overbed table, and tub shower bench. These items were observed in the patient's on 5/15/12 at 3:05 PM.</p> <p>2. Clinical record #2 included a plan of care for the certification period of 5/10/12-7/8/12 that failed to evidence the patient had a straight cane and shower bench. These items were observed in the patient's home on 5/15/12 at 12: 25 PM.</p> <p>3. Clinical record #3 included a plan of care for the certification period of 5/6/12-7/4/12 that failed to evidence the patient had a straight cane. This item was observed in the patient's home on 5/15/12 at 12:05 PM.</p> <p>4. Clinical record #4 included a plan of care for the certification period of 5/12/12-7/10/12 that failed to evidence the patient had a knee/flexor machine, and a post operative knee brace. These items were observed in the patient's home on 5/15/12 at 5:55 PM.</p> <p>5. Clinical record #6 included a plan of care for the certification period of 5/2/12-6/30/12 that failed to evidence a</p>		<p>record of all charts reviewed beginning June 7, 2012 and ending June 17, 2012 and indicate if all DME is recorded on the plan of care. The QA/PI Coordinator will be responsible for the audit. If more than 2 plans of care are out of compliance, the audit will continue for 30 more days and will be in full compliance by July 17, 2012. The inservice will be held on June 7, 2012. All DME will be recorded on the plan of care performed by June 17, 2012. The Director will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.</p>				

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	<p>straight cane and central dressing line supplies. These items were observed in the patient's home on 5/16/2012 at 10:35 AM.</p> <p>6. Clinical record #7 included a physical therapy assistant note dated 5/14/12 that identified the patient had a rolling walker. The plan of care for the certification period of 4/28/12-6/26/12 failed to evidence a rolling walker.</p> <p>7. Clinical record #8 included a physical therapy note dated 4/25/12 that identified the patient had a walker, bed side commode, and wheelchair. The plan of care for the certification period of 4/3/12-6/1/12 failed to evidence a walker, bedside commode, and wheel chair.</p> <p>8. Clinical record #9 included a physical therapy note dated 5/11/12 that identified the patient had a walker. The plan of care for the certification period of 4/21/12-6/19/12 failed to evidence a walker.</p> <p>9. Clinical record #10 included an occupational therapy note dated 4/25/12 that identified the patient had walker. A physical therapy note dated 4/11/12 identified the patient uses oxygen. The plan of care for the certification period of 3/25/12-5/23/12 failed to evidence a</p>						

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	<p>walker and oxygen.</p> <p>10. Clinical record #11 included a physical therapy note dated 5/14/12 that identified the patient had a walker and cane. The plan of care for the certification period of 5/11/12-7/9/12 failed to evidence a walker and cane.</p> <p>11. Clinical record #12 included a skilled nurse note dated 4/11/12 that identified the patient had oxygen. The plan of care for the certification period of 4/17/12-6/15/12 failed to evidence oxygen.</p> <p>12. On 5/15/2012 at 5/15/12 at 11:00 AM the manager, employee X, indicated no durable medical equipment would be on the plans of care because of a concern regarding Medicare billing since another vendor supplied the durable medical equipment.</p> <p>13. The agency policy revised date 7/19/02 and titled "Plan of Treatment" states, "At a minimum the plan of treatment must cover pertinent diagnoses,... types of services and equipment required ..."</p>				

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N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on clinical record review, interview, and policy review the agency failed to inform the physician of a change in the patient's needs for 1 of 12 clinical records reviewed (#10) with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #10, start of care 3/25/2012, evidenced the patient received occupational therapy (O.T.) services on 5/2, 5/4, 5/9/12 and was discharged from occupational therapy services on 5/14/12 without a physician's order. 2. On 5/16/2012 at 4:45 PM, the manager of the agency, employee X, indicated there were no O.T. orders for the patient. 3. The policy with a revised date of 7/19/02 titled "Plan of Care" states, "The physician is promptly alerted to any changes that suggest a need to alter the plan. The physician is consulted to approve additions or modifications to the original plan. Care must be rendered in 	N0545	<p>The deficiency occurred when the OT indicated accidentally in the computer system that the order did not need to go to the physician for signature. The initial order had been written on 5/2/12. On 5/18/12 the OT corrected the error in the computer system so the order would print. The order was then sent to the physician for signature and returned signed to the agency on 5/22/12. The OT was reinstructed in the correct procedures for physician orders to be denoted for printing for physician signature. The QA/PI Coordinator will monitor for accuracy of physician orders which she currently does in the normal course of her duties. The Director will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur</p>	05/18/2012			

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	conformance with each order on the plan of treatment. Any change of orders required while the plan is in effect can be made by writing a change of order and obtaining the physician's signature for the order."			

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N0597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on interview and review of personnel records, the agency failed to ensure the aide was entered on and in good standing on the home health registry within 3 days of patient contact for 1 of 5 home health aides (E) with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file E, date of hire 5/23/11 and first patient contact 6/6/11, failed to evidence the agency had checked to ensure the aide was entered on and in good standing on the home health aide registry. 2. On 5/16/12 at 2:30 PM, the manager of the agency, employee X, indicated employee E was not listed on the home health aide state registry but does have a certified nursing assistant registration. 	N0597	<p>The deficiency has been corrected and the appropriately completed papers were faxed to the State on 6/1/12. The deficiency will be prevented by sending a memo to the Supervisory and Clerical staff informing them of the process for Home Health Aide Certification. The Memo will be sent 6/4/12. The Director will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.</p>	06/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157143	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2012
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