

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/25/2012
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NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 702 NORTH SHORE DRIVE, SUITE 102 JEFFERSONVILLE, IN 47130
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G0000	<p>This visit was for a home health initial medicaid certification survey. This was a partial extended survey.</p> <p>Survey dates: 7/23-25/12</p> <p>Facility #012872</p> <p>Survey Team: Dawn Snider, RN, PHNS</p> <p>Census Service Type: 11</p> <p>Skilled Patients: 11 Home Health Aide Only Patients: 0 Personal Service Only Patients: 0</p> <p>Total: 11</p> <p>Sample:</p> <p>RR w HV: 3 RR w/o HV: 8 Phone interview with patient: 1</p> <p>Total RR: 11</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">July 30, 2012</p>	G0000		
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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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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review and interview, the agency failed to ensure the skilled nurse made visits as ordered on the plan of care and the physician was notified of the missed skilled nurse visit for 3 of 11 clinical records reviewed (7, 10, and 11) with the potential to affect all the patient's of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #7 included a plan of care for the certification period of 6/12/12-8/10/12 with orders for skilled nurse 2 times a week for 9 weeks. The record evidenced only 1 skilled nurse visit made on 06/12/12, the first week the patient was on service. The documentation failed to evidence the physician was notified of the missed skilled nurse visit.</p> <p>2. Clinical record #10 included a plan of care for the certification period of 7/3/12-9/1/12 with orders for skilled nurse 1 time a week for 9 weeks. The</p>	G0158	G 0158 The Director of Clinical Services will provide an inservice to the Administrator, Alt Admin and Supervising RN Nurse by August 8, 2012. The inservice will instruct that a missed visit communication sheet be faxed to the MD for every visit missed that is outside of the MD order, as stated on the Plan of Care. This sheet will be faxed to the MD, overseeing the Plan of Care, by the end of the week if the visit was truly missed for the week. The missed visit sheet and fax succession sheet will be maintained in the clinical record where the visit note would be. A missed visit communication sheet was created before the auditor left the office and an individual office PI plan was put into place. The MD's were also notified of the missed visits for clinical record #'s 7, 10 and 11, before the auditor left the office. 10% of all clinical records will be audited quarterly by the Director of Clinical Services to ensure missed visits are being send to the MD when a missed visit occurs. The Director of Clinical Services/Administrator or designee will be responsible for the monitoring of this corrective	08/10/2012

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	<p>record failed to evidence a skilled nurse visit was made the week of 7/15/12. The documentation failed to evidence the physician was notified of the missed skilled nurse visit.</p> <p>3. Clinical record #11 included a plan of care for the certification period of 7/3/12-9/1/12 with orders for skilled nurse 1 time a week for 9 weeks. The record failed to evidence a skilled nurse visit was made the week of 7/15/12. The documentation failed to evidence the physician was notified of the missed skilled nurse visit.</p> <p>4. On 7/25/12 at 10:10 AM the director of clinical services, the alternate administrator, and the administrator indicated the physician had been previously notified of the missed visits by the skilled nurse for patients #7, # 10 #11.</p>		<p>action to ensure the deficiency is corrected and will not recur.</p>				

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G0171	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit.</p> <p>Based on clinical record and policy review, and interview, the agency failed to ensure the registered nurse made an initial assessment visit within forty - eight hours of a physician referral or on the physician - ordered start of care date as required by agency policy for 2 of 11 (10 and 11) of clinical records reviewed with the potential to affect all the agency's new admissions.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #10, start of care 7/3/12, evidenced a intake/referral form with the date of referral 6/29/12 and the physician ordered start of care 6/29/12. The record failed to evidence an initial assessment visit was made within 48 hours of referral or on the physician - ordered start of care date. 2. Clinical record #11, start of care 7/3/12, had a referral date of 6/27/12 as indicated on 7/25/12 at 10:00 AM by the director of clinical services, alternate administrator, and the administrator. The record failed to evidence an initial assessment visit was made within 48 	G0171	<p>G 171The Director of Clinical Services will inservice the Administrator, Alt Admin and RN Nursing Supervisor by August 8, 2012. The inservice will include education that all referrals be admitted within 48 hours of the MD referral. The inservice will also include education that if a referral cannot be admitted within 48 hours due to staffing issues, etc, there needs to be documentation in the clinical record as to reason for delay in start of care. The MD, patient, and PCG would also need to be communicated with regarding the delay in start of care. 10% of all clinical records will be audited quarterly for evidence that an admission assessment was completed within 48 hours of the referral. If the assessment wasn't completed within 48 hours then the clinical record will show evidence/documentation for the delay in start of care and documented communication with the necessary parties. The Director of Clinical Services. Administrator, or desginee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	08/08/2012			

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	<p>hours of referral.</p> <p>3. The policy titled "Admission Criteria" dated 3/21/12 states, "4. Upon referral, the decision regarding acceptance of and initiation of service by licensed staff will be made within 48 hours of the referral or within 48 hours of the patients return home or knowledge of return home or on the physicians ordered start of care date."</p> <p>4. On 7/25/12 at 10:00 AM, the director of clinical services, alternate administrator, and the administrator indicated there was no further evidence as to the delay in the initial assessment visit for patients #10 and #11.</p>						

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G0332	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>Based on clinical record and policy review, and interview, the agency failed to ensure the registered nurse made an initial assessment visit within forty - eight hours of a physician referral or on the physician - ordered start of care date for 2 of 11 (10 and 11) of clinical records reviewed with the potential to affect all the agency's new admissions.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #10, start of care 7/3/12, evidenced a intake/referral form with the date of referral 6/29/12 and the physician ordered start of care 6/29/12. The record failed to evidence an initial assessment visit was made within 48 hours of referral or on the physician - ordered start of care date. 2. Clinical record #11, start of care 7/3/12, had a referral date of 6/27/12 as indicated on 7/25/12 at 10:00 AM by the director of clinical services, alternate administrator, and the administrator. The record failed to evidence an initial assessment visit was made within 48 	G0332	G0332 The Director of Clinical Services will inservice the Administrator, Alt Admin and RN Nursing Supervisor by August 8, 2012. The inservice will include education that all referrals be admitted within 48 hours of the MD referral. The inservice will also include education that if a referral cannot be admitted within 48 hours due to staffing issues, etc, there needs to be documentation in the clinical record as to reason for delay in start of care. The MD, patient, and PCG would also need to be communicated with regarding the delay in start of care. 10% of all clinical records will be audited quarterly for evidence that an admission assessment was completed within 48 hours of the referral. If the assessment wasn't completed within 48 hours then the clinical record will show evidence/documentation for the delay in start of care and documented communication with the necessary parties. The Director of Clinical Services, Administrator, or desginee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	08/08/2012			

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	<p>hours of referral.</p> <p>3. The policy titled "Admission Criteria" dated 3/21/12 states, "4. Upon referral, the decision regarding acceptance of and initiation of service by licensed staff will be made within 48 hours of the referral or within 48 hours of the patients return home or knowledge of return home or on the physicians ordered start of care date."</p> <p>4. On 7/25/12 at 10:00 AM, the director of clinical services, alternate administrator, and the administrator indicated there was no further evidence as to the delay in the initial assessment visit for patients #10 and #11.</p>						

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G0337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the medication profile was accurate for 10 of 11 records reviewed (Clinical records #1-10) 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 #1, start of care 6/27/12, evidenced a medication administration record (MAR) which combined both typed and handwritten medications. The list failed to evidence any start dates for the medications. 2. Clinical record #2, start of care 6/7/12, failed to evidence start dates for the medications listed on the MAR. 3. Clinical record #3, start of care 6/8/12, failed to evidence start dates for the medications listed on the MAR. 4. Clinical record #4, start of care 7/6/12, 	G0337	G0337The Director of Clinical Services will educate the RN Supervising Nurse by August 8, 2012. The inservice will include education regarding the Drug Regimen Review, all prescription and over the counter medications will be reviewed upon admission and recorded either on a laptop or handwritten. A copy will be put in the home chart as soon as it's available. Every effort will be used to obtain medication start dates for all meds, this includes via patient info, med bottles, or contacting the patient's pharmacy. Possible side effects and drug interactions will also be discussed with patient/PCG upon admission and with each recert visit or when a med changes. A drug classification sheet will accompany the med profile for the patient/PCG to review and will be present in the home chart. The medication profile will be updated with each med change and a current copy placed in the office clinical record and the home chart. Each clinical record will be reviewed by the Director of Clinical Services at time of	08/08/2012			

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	<p>evidenced an order on 7/19/12 for "Dilaudid to 4 mg 1-2 tabs q [every] 4 hours prn [as needed] pain." The MAR failed to evidence the dosage of 1-2 tabs.</p> <p>5. Clinical record #5, start of care 6/13/12, failed to evidence start dates for the medications listed on the MAR.</p> <p>6. Clinical record #6, start of care 6/25/12, failed to evidence start dates for the medications of Lexapro, Lamictal, Xanax, Dilantin, Lortab, Flexeril, and Seroquel listed on the MAR.</p> <p>7. Clinical record #7, start of care 6/12/12, evidenced a MAR with "Allopurinol 50 mg QD [every day]." "Allopurinol 300 mg QD" was listed on the plan of care. The MAR failed to evidence start dates for the medications Furosemide, Spironolactone, Ranitidine, INH, Allopurinol, and KDur.</p> <p>8. Clinical record #8, start of care 6/28/12, failed to evidence start dates for the medications listed on the MAR except for "clarify 7/19/12 1000 mg [milligrams]" written in the column next to Vitamin B 12.</p> <p>9. Clinical record #9, start of care 6/28/12, failed to evidence start dates for the medications listed on the MAR except</p>		<p>admission and recert to ensure med profiles have been accurately updated. 10% of all medical records will also be audited quarterly for evidence that medication profiles are accurate and complete. The Director of Clinical Services, Administrator, or designee will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>a start date of 6/13/12 for the medication Avodart.</p> <p>10. Clinical record #10, start of care 7/3/12, failed to evidence start dates for the medications listed on the MAR.</p> <p>11. The policy titled "Medication Profile" dated 3/21/2012 states, "3. The Medication Profile shall document: b. Date medication ordered or care initiated."</p> <p>12. The policy titled "Medication Reconciliation" dated 3/21/12 states, "3. The admission professional will review this medication list with the physician, and confirm those medications that are to be continued or discontinued. The doses will be confirmed with the physician and changes will be noted in the record and on the Physician Plan of Care."</p> <p>12. On 7/23/12 at 4:30 PM the supervising registered nurse indicated a lack of understanding about documentation of start dates for the medications on the MAR.</p>						

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N0000	<p>This visit was for a home health initial state licensure survey</p> <p>Survey dates: 7/23-25/12</p> <p>Facility #012872</p> <p>Survey Team: Dawn Snider, RN, PHNS</p> <p>Census Service Type: 11</p> <p>Skilled Patients:11 Home Health Aide Only Patients: 0 Personal Service Only Patients: 0</p> <p>Total: 11</p> <p>Sample:</p> <p>RR w HV: 3 RR w/o HV: 8 Phone interview with patient:1</p> <p>Total RR: 11</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">July 30, 2012</p>	N0000					

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N0522	<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:</p> <p>Based on clinical record review and interview, the agency failed to ensure the skilled nurse made visits as ordered on the plan of care and the physician was notified of the missed skilled nurse visit for 3 of 11 clinical records reviewed (7, 10, and 11) with the potential to affect all the patient's of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #7 included a plan of care for the certification period of 6/12/12-8/10/12 with orders for skilled nurse 2 times a week for 9 weeks. The record evidenced only 1 skilled nurse visit made on 06/12/12, the first week the patient was on service. The documentation failed to evidence the physician was notified of the missed skilled nurse visit.</p> <p>2. Clinical record #10 included a plan of care for the certification period of 7/3/12-9/1/12 with orders for skilled nurse 1 time a week for 9 weeks. The record failed to evidence a skilled nurse</p>	N0522	<p>N0522The Director of Clinical Services will provide an inservice to the Administrator, Alt Admin and Supervising RN Nurse by August 8, 2012. The inservice will instruct that a missed visit communication sheet be faxed to the MD for every visit missed that is outside of the MD order, as stated on the Plan of Care. This sheet will be faxed to the MD, overseeing the Plan of Care, by the end of the week if the visit was truly missed for the week. The missed visit sheet and fax succession sheet will be maintained in the clinical record where the visit note would be. A missed visit communication sheet was created before the auditor left the office and an individual office PI plan was put into place. The MD's were also notified of the missed visits for clinical record #'s 7, 10 and 11, before the auditor left the office. 10% of all clinical records will be audited quarterly by the Director of Clinical Services to ensure missed visits are being send to the MD when a missed visit occurs. The Director of Clinical Services/Administrator or designee will be responsible for the monitoring of this corrective</p>	08/08/2012			

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	<p>visit was made the week of 7/15/12. The documentation failed to evidence the physician was notified of the missed skilled nurse visit.</p> <p>3. Clinical record #11 included a plan of care for the certification period of 7/3/12-9/1/12 with orders for skilled nurse 1 time a week for 9 weeks. The record failed to evidence a skilled nurse visit was made the week of 7/15/12. The documentation failed to evidence the physician was notified of the missed skilled nurse visit.</p> <p>4. On 7/25/12 at 10:10 AM the director of clinical services, the alternate administrator, and the administrator indicated the physician had been previously notified of the missed visits by the skilled nurse for patients #7, # 10 #11.</p>		action to ensure the deficiency is corrected and will not recur.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2012	
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N0540	<p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit.</p> <p>Based on clinical record and policy review, and interview, the agency failed to ensure the registered nurse made an initial assessment visit within forty - eight hours of a physician referral or on the physician - ordered start of care date as required by agency policy for 2 of 11 (10 and 11) of clinical records reviewed with the potential to affect all the agency's new admissions.</p> <p>Findings include:</p> <p>1. Clinical record #10, start of care 7/3/12, evidenced a intake/referral form with the date of referral 6/29/12 and the physician ordered start of care 6/29/12. The record failed to evidence an initial assessment visit was made within 48 hours of referral or on the physician - ordered start of care date.</p> <p>2. Clinical record #11, start of care 7/3/12, had a referral date of 6/27/12 as indicated on 7/25/12 at 10:00 AM by the director of clinical services, alternate</p>	N0540	<p>N0540The Director of Clinical Services will provide an inservice to the Administrator, Alt Admin and Supervising RN Nurse by August 8, 2012. The inservice will instruct that a missed visit communication sheet be faxed to the MD for every visit missed that is outside of the MD order, as stated on the Plan of Care. This sheet will be faxed to the MD, overseeing the Plan of Care, by the end of the week if the visit was truly missed for the week. The missed visit sheet and fax succession sheet will be maintained in the clinical record where the visit note would be. A missed visit communication sheet was created before the auditor left the office and an individual office PI plan was put into place. The MD's were also notified of the missed visits for clinical record #'s 7, 10 and 11, before the auditor left the office. 10% of all clinical records will be audited quarterly by the Director of Clinical Services to ensure missed visits are being send to the MD when a missed visit occurs. The Director of Clinical Services/Administrator or designee will be responsible for</p>	08/08/2012			

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	<p>administrator, and the administrator. The record failed to evidence an initial assessment visit was made within 48 hours of referral.</p> <p>3. The policy titled "Admission Criteria" dated 3/21/12 states, "4. Upon referral, the decision regarding acceptance of and initiation of service by licensed staff will be made within 48 hours of the referral or within 48 hours of the patients return home or knowledge of return home or on the physicians ordered start of care date."</p> <p>4. On 7/25/12 at 10:00 AM, the director of clinical services, alternate administrator, and the administrator indicated there was no further evidence as to the delay in the initial assessment visit for patients #10 and #11.</p>		the monitoring of this corrective action to ensure the deficiency is corrected and will not recur.				