

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157569	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2014
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NAME OF PROVIDER OR SUPPLIER VNA HEALTHTRENDS	STREET ADDRESS, CITY, STATE, ZIP CODE 732 E US HWY 30 SCHERERVILLE, IN 46375
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G000000	<p>This was a home health federal recertification survey which resulted in a fully extended survey on 7/28/14.</p> <p>Survey date: 7/23/14 - 7/29/14</p> <p>Facility # 004608</p> <p>Medicaid # 200538740</p> <p>Surveyors: Ingrid Miller, RN, PHNS, Lead Surveyor</p> <p style="padding-left: 40px;">Susan E. Sparks, RN, MAE, PHNS</p> <p>507 skilled unduplicated patients for past year</p> <p>VNA Healthtrends is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning August 5, 2014, - August 5, 2016, due to being found out of compliance with the Conditions of Participation 42 CFR 484.14 Organization, services, and administration; 484.16: Group of Professional Personnel; 484.30 Skilled</p>	G000000		

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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G000110	<p>Nursing Services; and 484.52 Evaluation of the Agency's Program.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 5, 2014</p> <p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced</p>	G000110	The revised 7/1/2013 State of Indiana Advanced Directives document has been added to all admission packets as of 7/29/2014. In addition, the admission packet will be	08/29/2014

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	<p>Directives, including a description of applicable State law, in 12 of 12 records reviewed (#1 - 12).</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The admission book given to the patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana advanced directives in the admission folder that was distributed to the patients at the start of care (SOC). 2. On 7/24/14 at 3:15 PM, the vice president of operations, Employee B, indicated the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013) in patient # 1 - 12's home admission books and all the patients of the agency needed to receive the updated advanced directives. 3. Clinical record #1, SOC 7/2/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date. 4. Clinical record #2, SOC 7/10/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed 		<p>audited monthly to ensure compliance with the most current Advanced Directives document. The Indiana state regulatory website will also be checked monthly for ongoing updates to this document. An admission packet audit tool will be developed to ensure compliance. Monitoring will occur monthly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and do not recur.</p>				

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	<p>that the document was received on the SOC date.</p> <p>5. Clinical record #3, SOC 7/5/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>6. Clinical record #4, SOC 7/2/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>7. Clinical record #5, SOC 7/19/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>8. Clinical record #6, SOC 7/12/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>9. Clinical record #7, SOC 6/21/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced</p>				

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	<p>Directives document. The patient signed that the document was received on the SOC date.</p> <p>10. Clinical record #8, SOC 1/28/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>11. Clinical record #9, SOC 11/14/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>12. Clinical record #10, SOC 5/3/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>13. Clinical record #11, SOC 6/29/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>14. Clinical record #12, SOC 6/21/14, failed to contain an updated July 1, 2013,</p>				

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G000121	<p>version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>15. The agency document titled "Statement of Indiana Law on Advance Directives" with no effective date stated, "The Statement of Indiana Law on Advance Directives has been written in fulfillment of the Omnibus Budget Reconciliation Act of [Obra '90] requirement that the State prepare such a statement to be distributed by providers ... It is agency's policy to recognize the rights of its clients to make informed decisions about their medical care ... it is our policy to comply with the applicable law."</p> <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, interview, and review of policies and procedures, the agency failed to ensure registered nurses (RN) provided services in accordance</p>	G000121	Paula Lorance, RN, Administrator and Linda Krippel, RN, DON will inservice all nursing staff on Infection Control, Handwashing, Standard Precautions and Bag	08/29/2014

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	<p>with agency policy in 2 of 2 home visit observations (Patients #4 and #6) with a registered nurse (Employee I and Employee P).</p> <p>The findings include</p> <ol style="list-style-type: none"> 1. On 7/25/15 at 7 AM, Employee P, RN, was observed to don gloves and remove the wound dressing from patient # 4's abdominal wound and measure the wound. He did not remove his gloves after removing the old dressing or wash his hands before he proceeded to clean the wound area and apply the clean dressing for the wound vac treatment. He discarded all supplies and removed his gloves and then washed his hands. 2. On 7/25/14 at 9 AM, Employee I, RN, was observed at a home visit with patient #6. Employee I was observed to wash her hands and don clean gloves and then place all dressing supplies on the patient's living room floor. There was no barrier between these supplies, which included a Genadyne Foam Kit Thin Medium, 4 gauze dressings, clean gloves, skin preparation pad, and a saline wash bottle, and the floor. She removed the old dressing from the patient's left foot and discarded her gloves. She did not wash her hands. She applied clean gloves and dressed the wound and 		<p>Technique. All staff providing direct care will also be recompetencied on handwashing and bag technique. Monitoring will occur with on-site supervisory evaluations and competencies annually. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	

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G000122	<p>applied the wound vac.</p> <p>3. The agency policy titled "Hand hygiene" with a date revised of June 2012 stated, "Field providers will wash hands ... after removing soiled gloves."</p> <p>4. The agency policy titled "Standard Precautions" with a revised date of June 2012 stated, "Handwashing with an antibacterial soap, water, and hand sanitizer ... will be done before putting on protective gloves; B. upon removal of protective gloves."</p> <p>5. The agency policy titled "Bag contents and technique" with a revised date of June 2012 stated, "The floor is a grossly contaminated area ... open bag and remove supplies. Place them on a clean work area with appropriate barrier paper or drape."</p> <p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION</p>	G000122	Paula Lorance, RN, Administrator and Linda Krippele, RN, DON	08/29/2014			

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	<p>Based on personnel file review, agency website review, interview, agency document review, policy review, and clinical record review, it was determined the agency failed to ensure the state agency was notified of branch sites and branches were approved by the CMS prior to functioning as a branch (See G 125); failed to ensure the personnel policies were followed in 6 of 20 employee records reviewed (see G 141); and failed to ensure all personnel communicated and coordinated services to support the plan of care in 2 of 12 records reviewed(see G 143 and G 144).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.14 Organization, services, and administration.</p>		<p>will ensure any and all information implying Richmond IN is a branch of Schererville IN is removed. The signage and posted hours have been removed, the 765 area code number is being disconnected and any website listings are being changed to reflect our toll-free number and Schererville address. There are no additional locations in Indiana being operated as branches. Monitoring would occur with an on-site visit to ensure the signage and posted hours are removed. A website search would also be conducted. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 1. All outstanding employee paperwork will be obtained and placed in the employee personnel files. In addition, all personnel files will be audited to ensure compliance with applicable requirements. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 2. The state aide registry will be checked annually to ensure that aides are registered as both certified</p>	

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			nurses' aides and home health aides. In addition, policy #913 has been reviewed and revised to include home health aide services. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 3. All licensed professional staff will provide proof of necessary credentials and sign a job description at time of hire. Monitoring will occur by auditing the employee personnel file at time of hire, then quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 4. The professional licenses of all field staff will be verified annually. Policy #909 has been reviewed and revised to include verification of licensure for all professional staff annually. Monitoring will occur by verifying all professional licenses at time of hire, upon license renewal, then quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 5. All	

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G000125	484.14 ORGANIZATION, SERVICES &		performance reviews will be conducted annually. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and does not recur. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff regarding coordination of care between disciplines as defined in Policy #304. In addition, 100% of the deficient records during survey and 100% of all new clinical records post inservice were audited with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will occur by auditing 100% of the deficient records as well as 100% of all new clinical records post inservice. 10% of all clinical records will then be audited monthly for 1 year to ensure proper coordination of care between disciplines is occurring. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.		

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	<p>ADMINISTRATION All services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency.</p> <p>6. On 7/23/14 at 9:50 AM, the off site area of the home health agency was entered at 950 South A St, Richmond, Indiana 47374. The only person present was the Marketer, Employee W.</p> <p>A. The off site area has signage viewable from the street and viewable from the inside of the assisted living facility in which it is located. Hours are posted on the door.</p> <p>B. A 765 area code number is listed for the agency. The Marketer, Employee W, indicated she answers that number on her cell phone. She takes the referral information and meets with the patient if necessary. She has a specific area that she works in, Richmond being part of it. When she is done with the referral she sends it to the appropriate staff member.</p> <p>C. The Marketer, Employee W, indicated all records are electronic and everything she does is immediately scanned into the clinical records.</p> <p>D. The off site area is open when the Marketer, Employee W, is there; when</p>	G000125	Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will ensure any and all information implying Richmond IN is a branch of Schererville IN is removed. The signage and posted hours have been removed, the 765 area code number is being disconnected and any website listings are being changed to reflect our toll-free number and Schererville address. There are no additional locations in Indiana being operated as branches. Monitoring would occur with an on-site visit to ensure the signage and posted hours are removed. A website search would also be conducted. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 1. All outstanding employee paperwork will be obtained and placed in the employee personnel files. In addition, all personnel files will be audited to ensure compliance with applicable requirements. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be	08/29/2014

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	<p>she leaves she locks it up. The hours posted are ignored. She does not know if the therapist or nurses have keys or if they have the assisted living unlock the door if they need to work in the room.</p> <p>7. On 7/23/14 at 10:00 AM, the Director of Nursing, Employee A, in Schererville, indicated the off site area is a "meeting room" used for training.</p> <p>8. On 7/23/14 at 10:30 AM, the Director of Nursing, Employee A, requested to call the local Registered Nurse and have the nurse come to the off site area to help with the survey.</p> <p>At 10:57 AM, the local Registered Nurse, Employee D, called the off site area and said she was in meetings all day at her full time job and would not come.</p>		<p>responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 2. The state aide registry will be checked annually to ensure that aides are registered as both certified nurses' aides and home health aides. In addition, policy #913 has been reviewed and revised to include home health aide services. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 3. All licensed professional staff will provide proof of necessary credentials and sign a job description at time of hire. Monitoring will occur by auditing the employee personnel file at time of hire, then quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 4. The professional licenses of all field staff will be verified annually. Policy #909 has been reviewed and revised to include verification of licensure for all professional staff annually. Monitoring will occur by verifying all professional licenses at time of hire, upon license renewal, then quarterly</p>		

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			and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 5. All performance reviews will be conducted annually. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and does not recur. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff regarding coordination of care between disciplines as defined in Policy #304. In addition, 100% of the deficient records during survey and 100% of all new clinical records post inservice were audited with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will occur by auditing 100% of the deficient records as well as 100% of all new clinical records post inservice. 10% of all clinical records will then be audited monthly for 1 year to ensure proper coordination of care between disciplines is occurring. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for	

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G000141	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on personnel file and policy review and interview, the agency failed to ensure the personnel policies were followed in 5 of 20 employee records reviewed (Employee E, J, L, O , R) with the potential to affect all the 204 active patients of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> Employee E, occupational therapist, date of hire 3/10/14 and first patient contact 3/10/14, failed to evidence a job description had been completed upon hire. Employee J, home health aide, date of hire 2/1/13 and first patient contact 2/25/13, failed to evidence the aide had been verified as in good standing on the state aide registry. Employee L, home health aide, date of hire 5/22/14 and first patient contact 	G000141	<p>monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p> <ol style="list-style-type: none"> All outstanding employee paperwork will be obtained and placed in the employee personnel files. In addition, 100% of the personnel files will be audited to ensure compliance with applicable requirements. Monitoring will occur by auditing 100% of the employee personnel files by 8/29/2014, then quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. The state aide registry will be checked annually to ensure that aides are registered as both certified nurses' aides and home health aides. In addition, policy #913 has been reviewed and revised to include home health aide services. In addition, all aide files will be audited to ensure compliance with applicable requirements. Monitoring will occur by auditing 100% of the aide personnel files by 8/29/2014, 	08/29/2014

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	<p>6/11/14, failed to evidence a job description had been signed at the time of hire. The file also evidenced the home health aide had not been verified as in good standing on the state aide registry.</p> <p>4. Employee O, occupational therapist, date of hire 1/10/08 and first patient contact 3/20/10, failed to evidence an annual performance evaluation had been completed.</p> <p>5. Employee R, home health aide, date of hire 3/1/13 and first patient contact 3/2/13, failed to evidence the aide had been verified as in good standing on the state aide registry.</p> <p>6. On 7/29/14 at 4:05 PM, Employee V, human resources, indicated the personnel files were not complete.</p> <p>7. The agency policy titled "Employee Handbook" with a date of November 2012 stated, "The agency will have written competencies for field providers ... staff who must have a licensure and / or certification in order to provide proof of necessary credentials at the time of hire and annually ... Additional formal performance reviews are conducted on the employee anniversary date annually."</p> <p>8. The agency policy titled "Job</p>		<p>then quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 3. All licensed professional staff will provide proof of necessary credentials and sign a job description at time of hire. Monitoring will occur by auditing the employee personnel file at time of hire, then quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 4. The professional licenses of all field staff will be verified by 8/29/2014, then annually. Policy #909 has been reviewed and revised to include verification of licensure for all professional staff annually. Monitoring will occur by verifying all professional licenses at time of hire, upon license renewal, then annually. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 5. All performance reviews will be conducted annually. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and</p>	

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G000143	<p>descriptions" with a date of June 2012 stated, "There will be a job description for each employee position that states qualifications, defines roles, and list responsibilities."</p> <p>9. The agency policy titled "Employee evaluation Performance Appraisal" with a date of June 2012 stated, "Agency staff may receive a written evaluation after 90 days as indicated and annually .. to comply with government regulations."</p> <p>10. The agency policy titled "CNA services" with a review date of June 2012 stated, "CNA services will be provided to clients throughout this agency in compliance with federal and state regulations." (There was no policy in the agency covering home health aide services.)</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on clinical record and agency</p>	G000143	<p>Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and does not recur.</p> <p>Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy</p>	08/29/2014

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	<p>policy review and interview, the agency failed to ensure all personnel communicated and coordinated services to support the plan of care in 2 (# 7 and 10) of 12 records reviewed creating the potential to affect all of the agency's 204 current patients.</p> <p>The findings include</p> <p>1. Clinical record # 7, start of care 6/21/14, included a plan of care for the certification period of 6/21/14 - 8/19/14 with orders for skilled nursing, occupational therapy and physical therapy. The clinical record failed to show that any coordination of care had occurred between these services to support the patient's plan of care. Skilled nursing visits were on 6/21/14, 6/25/14, 7/1/14, 7/4/14, 7/8/14, 7/15/14, and 7/22/14. Occupational therapy visits were on 6/27/14, 7/2/14, 7/4/14, 7/18/14, and 7/19/14. Physical therapy visits were on 7/23/14, 6/25/14, 7/2/14, 7/9/14, 7/9/14, 7/11/14, 7/15/14, 7/16/14, and 7/18/14.</p> <p>On 7/28/14 at 12:30 PM, Employee B, vice president of operations, indicated there was no coordination of care between these services caring for the patient.</p>		<p>staff regarding coordination of care between disciplines as defined in Policy #304. In addition, 100% of the deficient records during survey and 100% of all new clinical records post inservice were audited with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will occur by auditing 100% of the deficient records as well as 100% of all new clinical records post inservice. 10% of all clinical records will then be audited monthly for 1 year to ensure proper coordination of care between disciplines is occurring. Paula Lorance, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	

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	<p>2. Clinical record #10, start of care 5/3/14, included a plan of care for the certification period of 5/3/14 - 7/1/14 with orders for occupational therapy and physical therapy. There was no documentation to show that the physical therapist and occupational therapist had communicated and coordinated services to support the patient's plan of care. Physical therapy visits occurred on 5/3/14, 5/8/14, 5/14/14, 5/17/14, 5/24/14. Occupational therapy visits occurred on 5/9/14, 5/15/14, 5/17/14, 5/19/14, 5/22/14, 5/30/14, and 5/31/14.</p> <p>On 7/28 at 4:50 PM, Employee B indicated there was no coordination of care between the services caring for this patient.</p> <p>3. The agency policy titled "Coordination of care" with a date of June 2012 stated, "A registered nurse, physical therapist, or speech therapist will be assigned to coordinate the care of each client from admission to discharge. This RN, PT, or ST will be responsible for coordination of the home care team's communication and the client's plan of care ... to comply with government regulations ... to facilitate continuity of care; to assure appropriate care."</p>			

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G000144	<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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure all personnel communicated and coordinated services to support the plan of care in 2 (#s 7 and 10) of 12 records reviewed creating the potential to affect all of the agency's 204 current patients.</p> <p>The findings include</p> <p>1. Clinical # 7, start of care 6/21/14, included a plan of care for the certification period of 6/21/14 - 8/19/14 with orders for skilled nursing, occupational therapy and physical therapy. The clinical record failed to show that any coordination of care had</p>	G000144	<p>Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff regarding coordination of care between disciplines as defined in Policy #304. In addition, 100% of the deficient records during survey and 100% of all new clinical records post inservice were audited with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will occur by auditing 100% of the deficient records as well as 100% of all new clinical records post inservice. 10% of all clinical records will then be audited monthly for 1 year to ensure proper coordination of care between disciplines is occurring. Paula Lorange, RN, Administrator and Linda Krippel,</p>	08/29/2014

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	<p>occurred between these services to support the patient's plan of care. Skilled nursing visits were on 6/21/14, 6/25/14, 7/1/14, 7/4/14, 7/8/14, 7/15/14, and 7/22/14. Occupational therapy visits were on 6/27/14, 7/2/14, 7/4/14, 7/18/14, and 7/19/14. Physical therapy visits were on 7/23/14, 6/25/14, 7/2/14, 7/9/14, 7/9/14, 7/11/14, 7/15/14, 7/16/14, and 7/18/14.</p> <p>On 7/28/14 at 12:30 PM, Employee B, vice president of operations, indicated there was no coordination of care between these services caring for the patient.</p> <p>2. Clinical record #10, start of care 5/3/14, included a plan of care for the certification period of 5/3/14 - 7/1/14 with orders for occupational therapy and physical therapy. There was no documentation to show that the physical therapist and occupational therapist had communicated and coordinated services to support the patient's plan of care. Physical therapy visits occurred on 5/3/14, 5/8/14, 5/14/14, 5/17/14, 5/24/14. Occupational therapy visits occurred on 5/9/14, 5/15/14, 5/17/14, 5/19/14, 5/22/14, 5/30/14, and 5/31/14.</p> <p>On 7/28 at 4:50 PM, Employee B indicated there was no coordination of</p>		RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.		

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G000151	<p>care between the services caring for this patient.</p> <p>3. The agency policy titled "Coordination of care" with a date of June 2012 stated, "A registered nurse, physical therapist, or speech therapist will be assigned to coordinate the care of each client from admission to discharge. This RN, PT, or ST will be responsible for coordination of the home care team's communication and the client's plan of care ... to comply with government regulations ... to facilitate continuity of care; to assure appropriate care."</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL Based on policy and administrative document review and interview, it was determined the agency failed to ensure a group of professional personnel was formed and included representation of a physician and other disciplines that provided services on behalf of the agency (see G 152); failed to ensure a group of professional personnel was formed that reviewed and approved the agency's policies and participated in a plan for the annual program evaluation (see G 153); failed to ensure a Group of Professional Personnel that included at least physician and other health care professionals met</p>	G000151	A Professional Advisory Committee meeting will be held by 8/29/14 and at least annually thereafter. Monitoring will occur as part of the annual Board of Directors' meeting. Barbara Hills, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure this deficiency is corrected and does not recur.	08/29/2014

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G000152	<p>frequently and completed the annual program evaluation (See G 154); and failed to ensure a group of professional personnel was formed and met on behalf of the agency and had documented dated minutes (See G 155).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.16: Group of Professional Personnel.</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines. Based on policy and administrative document review and interview, the agency failed to ensure a group of professional personnel was formed and met on the behalf of the agency in 1 of 1 agency reviewed.</p> <p>Findings</p> <p>1. On 7/29/14 at 3:30 PM, Employee B,</p>	G000152	A Professional Advisory Committee meeting will be held by 8/29/14 and annually thereafter. In addition, performance data and outcomes will be analyzed quarterly and submitted to corporate leadership for review. This data will also be presented for evaluation at the Professional Advisory Committee meeting. Monitoring will occur as part of the annual	08/29/2014

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	<p>the vice president of operations, indicated the corporate Professional Advisory Committee / senior management met every month to discuss corporate and agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio.</p> <p>2. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and Indiana. However, there was not any professional advisory group solely for this agency.</p> <p>3. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual performance improvement evaluation report will be prepared during the fourth</p>		<p>Board of Directors' meeting. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorance, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and does not recur.</p>		

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G000153	<p>quarter of the year and integrated into the agency - wide annual evaluation report."</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. Based on policy and administrative document review and interview, the agency failed to ensure a group of professional personnel that included at least one physician and other health care professionals completed a review of the agency's policies for 1 of 1 agency.</p> <p>Findings</p> <p>1. On 7/29/14 at 3:30 PM, Employee B, the vice president of operations, indicated the corporate Professional Advisory Committee / senior management met every month to discuss corporate and</p>			G000153	<p>A Professional Advisory Committee meeting will be held by 8/29/14 and at least annually thereafter. In addition, performance data and outcomes will be analyzed quarterly and submitted to corporate leadership for review. This data will also be presented for evaluation at the annual Professional Advisory Committee meeting. Monitoring will occur as part of the annual Board of Directors' meeting. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure this</p>		08/29/2014

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	<p>agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio.</p> <p>2. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and Indiana. However, there was not any professional advisory group solely for this agency.</p> <p>3. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual performance improvement evaluation report will be prepared during the fourth quarter of the year and integrated into the agency - wide annual evaluation report."</p>		deficiency is and does not recur.				

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G000154	<p>484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.</p> <p>Based on policy and agency document review and interview, the agency failed to ensure a Group of Professional Personnel that included at least physician and other health care professionals met frequently and completed the annual program evaluation for 1 of 1 agency.</p> <p>Findings</p> <p>1. On 7/29/14 at 3:30 PM, Employee B, the vice president of operations, indicated the corporate Professional Advisory Committee / senior management met every month to discuss corporate and agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio.</p> <p>2. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and</p>	G000154	<p>A Professional Advisory Committee meeting will be held by 8/29/14 and at least annually thereafter. In addition, performance data and outcomes will be analyzed quarterly and submitted to corporate leadership for review. This data will also be presented for evaluation at the Professional Advisory Committee meeting. Monitoring will occur as part of the annual Board of Directors' meeting. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and does not recur.</p>	08/29/2014

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G000155	<p>Indiana. However, there was not any professional advisory group solely for this agency.</p> <p>3. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual performance improvement evaluation report will be prepared during the fourth quarter of the year and integrated into the agency - wide annual evaluation report."</p> <p>484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel's</p>				

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	<p>meetings are documented by dated minutes. Based on policy and administrative document review and interview, the agency failed to ensure a group of professional personnel was formed and met on the behalf of the agency and had documented dated minutes in 1 of 1 agency reviewed.</p> <p>Findings</p> <ol style="list-style-type: none"> On 7/29/14 at 3:30 PM, Employee B, the vice president of operations, indicated the corporate Professional Advisory Committee / senior management met every month to discuss corporate and agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and Indiana. However, there was not any professional advisory group solely for this agency. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership 	G000155	<p>A Professional Advisory Committee meeting will be held by 8/29/14 and at least annually thereafter. In addition, performance data and outcomes will be analyzed quarterly and submitted to corporate leadership for review. This data will also be presented for evaluation at the annual Professional Advisory Committee meeting. Monitoring will occur as part of the annual Board of Directors' meeting. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure these deficiencies are corrected and does not recur.</p>	08/29/2014

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G000158	<p>on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual performance improvement evaluation report will be prepared during the fourth quarter of the year and integrated into the agency - wide annual evaluation report."</p> <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, policy review, observation, and interview, the agency failed to ensure care visits and treatments were provided as ordered on the plan of care for 5 of 12 records reviewed (#3, #4, #6, #7, #10). Findings</p>	G000158	Paula Lorance, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff on the necessity of following the plan of care. In addition, 100% of all new clinical records post inservice were reviewed with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will	08/29/2014

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	<p>1. Clinical record #3, start of care (SOC) 7/5/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/5/14 - 9/2/14 with orders for skilled nursing to visit four times a week for one week, 3 times a week for 2 weeks, 1 time a week for two weeks, and 1 time every 2 weeks. The skilled nurse was to report a pattern of blood glucose levels over 350 milligram / dl. There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day. The skilled nurse was to perform / instruct / reinforce client / caregiver procedure of wound car to left foot surgical wound three times a week, cleanse with wound cleanser, pat dry. Apply iodoform packing. Cover with dry gauze and abdominal pad. Then secure with kerlix and tape using clean technique. At visits on 7/5/14, 7/9/14, 7/11/14, 7/12/14, 7/14/14, 7/16/14, 7/19/14, and 7/21/14, the skilled nurse used telfa to dress the wound. The record failed to evidence an order for Telfa to be used to dress the wound.</p> <p>On 7/24/14 at 3:40 PM, Employee B, vice president of operations, indicated that the patient was not taught to keep a blood sugar log and that telfa was not ordered on the plan of care.</p>		occur by auditing 100% of all new clinical records post inservice by 8/29/2014, then 10% of all clinical records will be audited monthly for 1 year to ensure compliance. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	

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	<p>2. Clinical record #4, SOC 7/2/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/2/14 - 8/30/14 with orders for skilled nursing to visit 2 times a week for one week, 3 times a week for 5 weeks, and 2 times a week for 3 weeks. The skilled nurse was to provide instructions / reinforcement of diabetic care to include diet, skin care, blood glucose testing and the skilled nurse to report a pattern of blood glucose levels greater than 250 mg / dl [milligram / deciliter]. There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day.</p> <p>On 7/24/14 at 4:05 PM, Employee B indicated the patient should have been instructed to keep a blood sugar log to show the blood sugar patterns for this patient.</p> <p>3. Clinical record #6, SOC 7/12/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/12/14 - 9/9/14 with orders for skilled nursing to visit 1 times a week for 1 week, 3 times a week for 3 weeks, 2 times a week for 5 weeks, and 1 times a week for 1 week. The skilled nurse was to cleanse the wound</p>			

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	<p>with wound wash, fill the entire cavity with green vac foam, apply tubing and cover with transparent drape, apply wound vac device at 125 mm [millimeter] continuous. Apply dressing every 48 hours (This should have been three times a week).</p> <p>On 7/25/14 at 9 AM, the registered nurse, Employee I, was observed to apply the wound vac dressing by filling the wound cavity with green foam, cover with transparent drape and apply tubing. After applying the tubing, the nurse added the extra green foam to cushion the wound vac dressing and tubing. There was no order for adding the extra foam over the transparent drape and tubing.</p> <p>4. Clinical record #7, SOC 6/21/14 and diagnosis of surgical hip repair, included a plan of care for the certification period of 6/21/14 - 8/19/14 with orders for the home health aide to visit 2 times a week for two weeks and then one times a week for two weeks. The aide during visited only once the first week on 6/25/14 and only once the second week on 7/3/14. The plan of care had orders for the occupational therapist to visit one times a week for one week and then two times a week for three weeks and orders for the physical therapist to visit 1 times a week for one week and then two times a week</p>			

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	<p>for 5 weeks. The physical therapist only made one visit on July 2nd (the second week). The occupational therapist only made one visit on July 12th (the third week).</p> <p>On 7/28/14 at 12:30 PM, Employee B indicated the home health aide, occupational therapist, and physical therapist did not visit according to the plan of care.</p> <p>5. Clinical record #10 SOC 5/3/14 and diagnosis of other specified rehabilitation procedure, generalized muscle weakness, depressive disorder, and unspecified peripheral vertigo, included a plan of care with orders for physical therapy orders 1 times a week for 2 weeks, 2 times a week for one week, and 1 times a week and occupational therapy orders for 1 times a week and two times a week for three weeks. The physical therapist visited on 5/3/14, 5/8/14, 5/14/14, 5/24/14. The occupational therapist visited on 5/9/14, 5/15/14, 5/17/14, 5/19/14, 5/22/14, 5/30/14, and 5/31/14. The physical therapist failed to visit the patient twice during the week of 5/11/14 - 5/17/14.</p> <p>On 7/28/14 at 4:50 PM, Employee B indicated the physical therapist did not visit the patient as ordered on the plan of care.</p>			

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	<p>6. The agency policy titled "Physician's orders" with a date of June 2012 stated, "Medications and treatments will be administered by agency field provider as ordered by a licensed physician ... all orders must be obtained in compliance with state and / or federal regulations."</p> <p>7. The agency policy titled "Plan of Care" with a date of June 2012 stated, "Home health care services are provided under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of services to the client's condition ... to ensure the provision of quality and legally approved home health care services ... home health care services are provided to clients a. under the general supervision of a physician b. based on a client plan of care established and periodically reviewed by physician to ensure appropriate application of the services to condition."</p>			

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G000159	<p>484.18(a) PLAN OF CARE 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 clinical record review, interview, and policy review, the agency failed to ensure the plan of care included all the required elements in 4 of 12 records reviewed (#1, 2, 6, 8) with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #1, Start of care (SOC) 7/2/14 and diagnosis of unspecified hypertension, cellulitis, and esophageal reflux, failed to evidence an individualized plan of care for the certification period of 7/2/14 - 8/30/14.</p>	G000159	Barbara Hill, RN, Vice President of Clinical Services has inserviced the Administrator, Director of Nursing, Documentation Review staff, and all nursing and therapy staff on the necessity of individualizing the plan of care. In addition, 100% of all new clinical records post inservice were audited with 100% compliance achieved. Monitoring will occur by auditing 100% of all new clinical records after inservicing then 10% monthly for 1 year to ensure compliance. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.	08/29/2014

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	<p>The plan of care included orders for physical therapy to instruct safe transfers (bed, bath, toilet, sofa, chair, and commode) using appropriate body mechanics and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). The patient's plan of care evidenced that the patient had a cane, shower / tub equipment, and walker and did not have a sliding board, Hoyer lift, trapeze, and / or wheelchair. The goals for this plan of care did not address care for this patient pertaining to the esophageal reflux diagnosis.</p> <p>On 7/25/14 at 3:45 PM, Employee B, vice president of operations, indicated the plan of care was not individualized and no goals addressed esophageal reflux on the plan of care.</p> <p>2. Clinical record #2, SOC 7/10/14 and diagnosis of after care of hip replacement, failed to evidence that the plan of care for the certification period of 7/10/14 - 9/7/14 that included all the patient's durable medical equipment including the patients CPAP machine that the patient used each night. The plan of care failed to evidence an individualized plan of care. There were orders for physical therapy to instruct safe transfers (bed, bath, toilet, sofa, chair, and commode) using appropriate body</p>			

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	<p>mechanics and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). The patient's plan of care evidenced that the patient had a cane, shower / tub equipment, and walker and did not have a sliding board, Hoyer lift, trapeze, and / or wheelchair.</p> <p>On 7/24/14 at 9:20 AM, patient #2 indicated using a CPAP machine each night for sleep apnea and using a cane and walker for transferring.</p> <p>3. Clinical record #6, SOC 7/12/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/12/14 - 9/9/14. This plan of care included an order that stated, "Skilled nurse to cleanse wound with wound wash. Fill entire cavity with green vac foam. Apply tubing and cover with transparent drape. Apply wound vac at 125 mm [millimeters] pressure continuous. Change dressing every 48 hours."</p> <p>On 7/25/14 at 10 AM, Employee B indicated the correct order would be to change the wound vac dressing three times a week not every 48 hours.</p> <p>4. Clinical record #8, SOC 1/28/14 and diagnosis of congestive heart failure, included plans of care for the</p>			

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G000168	<p>484.30</p> <p>certification periods of 1/18/14 - 3/28/14 with a physician's signature of 3/14/14 and a certification period of 5/28/14 - 7/16/14 with a physician's signature on 7/2/14.</p> <p>On 7/28/14 at 4 PM, Employee B indicated the physician's signatures were late on these plans of care.</p> <p>5. The agency policy titled "Plan of care" with a date of June 2012 state, "Home Health services are provided under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of services to the client's condition. Purpose to ensure the provision of quality and legally approved home health care services ... The client's plan of care is developed by a physician in consultation with field providers B. includes the following ... type of home health care services required ... client's treatment ... client's permitted activity ... rehabilitation and therapy services... medical supplies / appliances necessary ... review of client's plan of care ... any other appropriate items."</p>			

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G000170	<p>SKILLED NURSING SERVICES</p> <p>Based on clinical record review, policy review, observation, and interview, it was determined the agency failed to ensure skilled nursing services were provided as ordered on the plan of care for 3 of 12 records reviewed (see G 170), registered nurses observed were knowledgeable in wound care and infection control at 2 of 2 home visits observed with registered nurses (see G 174), the registered nurse (RN) had initiated interventions to address identified nursing needs in 1 of 12 records reviewed (#1), and all personnel communicated and coordinated services to support the plan of care in 1 of 12 records reviewed.</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.30 Skilled Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p>	G000168	<p>Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff on following the plan of care, infection control and coordination of care between disciplines. In addition, 100% of all new clinical records were audited post inservice with 100% compliance achieved. 10% of all records will then be audited monthly. Monitoring will occur by auditing 100% of all new clinical records post inservice, then 10% of all clinical records monthly for 1 year to ensure compliance. On-site supervisory evaluations and competencies will also occur annually. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	08/29/2014
		G000170	<p>Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have</p>	08/29/2014

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	<p>Based on clinical record review, policy review, observation, and interview, the agency failed to ensure care by the registered nurse was provided as ordered on the plan of care for 3 of 12 records reviewed (#3, #4, #6,).</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) 7/5/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/5/14 - 9/2/14 with orders for skilled nursing to visit four times a week for one week, 3 times a week for 2 weeks, 1 time a week for two weeks, and 1 time every 2 weeks. The skilled nurse was to report a pattern of blood glucose levels over 350 milligram / dl. There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day. The skilled nurse was to perform / instruct / reinforce client / caregiver procedure of wound car to left foot surgical wound three times a week, cleanse with wound cleanser, pat dry. Apply iodoform packing. Cover with dry gauze and abdominal pad. Then secure with kerlix and tape using clean technique. At visits on 7/5/14, 7/9/14, 7/11/14, 7/12/14, 7/14/14, 7/16/14, 7/19/14, and 7/21/14, the skilled nurse used telfa to dress the wound. The record</p>		<p>inserviced all nursing and therapy staff on the necessity of following the plan of care. In addition, 100% of all new clinical records post inservice were reviewed with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will occur by auditing 100% of all new clinical records post inservice by 8/29/2014, then 10% of all clinical records will be audited monthly for 1 year to ensure compliance. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON 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>failed to evidence an order for Telfa to be used to dress the wound.</p> <p>On 7/24/14 at 3:40 PM, Employee B, vice president of operations, indicated that the patient was not taught to keep a blood sugar log and that telfa was not ordered on the plan of care.</p> <p>2. Clinical record #4, SOC 7/2/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/2/14 - 8/30/14 with orders for skilled nursing to visit 2 times a week for one week, 3 times a week for 5 weeks, and 2 times a week for 3 weeks. The skilled nurse was to provide instructions / reinforcement of diabetic care to include diet, skin care, blood glucose testing and the skilled nurse to report a pattern of blood glucose levels greater than 250 mg / dl [milligram / deciliter]. There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day.</p> <p>On 7/24/14 at 4:05 PM, Employee B indicated the patient should have been instructed to keep a blood sugar log to show the blood sugar patterns for this patient.</p> <p>3. Clinical record #6, SOC 7/12/14 and</p>			

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	<p>diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/12/14 - 9/9/14 with orders for skilled nursing to visit 1 times a week for 1 week, 3 times a week for 3 weeks, 2 times a week for 5 weeks, and 1 times a week for 1 week. The skilled nurse was to cleanse the wound with wound wash, fill the entire cavity with green vac foam, apply tubing and cover with transparent drape, apply wound vac device at 125 mm [millimeter] continuous. Apply dressing every 48 hours (This should have been three times a week).</p> <p>On 7/25/14 at 9 AM, the registered nurse, Employee I, was observed to apply the wound vac dressing by filling the wound cavity with green foam, cover with transparent drape and apply tubing. After applying the tubing, the nurse added the extra green foam to cushion the wound vac dressing and tubing. There was no order for adding the extra foam over the transparent drape and tubing.</p> <p>4. The agency policy titled "Physician's orders" with a date of June 2012 stated, "Medications and treatments will be administered by agency field provider as ordered by a licensed physician ... all orders must be obtained in compliance with state and / or federal regulations."</p>			

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G000174	<p>5. The agency policy titled "Plan of Care" with a date of June 2012 stated, "Home health care services are provided under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of services to the client's condition ... to ensure the provision of quality and legally approved home health care services ... home health care services are provided to clients a. under the general supervision of a physician b. based on a client plan of care established and periodically reviewed by physician to ensure appropriate application of the services to condition."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill.</p>			
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	<p>Based on observation, interview, and review of policies and procedures, the agency failed to ensure registered nurses (RN) (Employee I and P) were knowledgeable in wound care and infection control at 2 of 2 home visits (4 and 6) observed with registered nurses.</p> <p>The findings include</p> <ol style="list-style-type: none"> On 7/25/15 at 7 AM, Employee P, RN, was observed to don gloves and remove the wound dressing from patient # 4's abdominal wound and measure the wound. He did not remove his gloves after removing the old dressing or wash his hands before he proceeded to clean the wound area and apply the clean dressing for the wound vac treatment. He discarded all supplies and removed his gloves and then washed his hands. On 7/25/14 at 9 AM, Employee I, RN, was observed at a home visit with patient #6. Employee I was observed to wash her hands and don clean gloves and then place all dressing supplies on the patient's living room floor. There was no barrier between these supplies, which included a Genadyne Foam Kit Thin Medium, 4 gauze dressings, clean gloves, skin preparation pad, and a saline wash bottle, and the floor. She removed the old dressing from the patient's left foot 	G000174	<p>Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing staff on Infection Control, Handwashing, Standard Precautions and Bag Technique. Monitoring will occur with on-site supervisory evaluations and competencies annually. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	08/29/2014			

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G000175	<p>and discarded her gloves. She did not wash her hands. She applied clean gloves and dressed the wound and applied the wound vac.</p> <p>3. The agency policy titled "Hand hygiene" with a date revised of June 2012 stated, "Field providers will wash hands ... after removing soiled gloves."</p> <p>4. The agency policy titled "Standard Precautions" with a revised date of June 2012 stated, "Handwashing with an antibacterial soap, water, and hand sanitizer ... will be done before putting on protective gloves; B. upon removal of protective gloves."</p> <p>5. The agency policy titled "Bag contents and technique" with a revised date of June 2012 stated, "The floor is a grossly contaminated area ... open bag and remove supplies. Place them on a clean work area with appropriate barrier paper or drape."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p>			

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified problems with wounds in 1 of 12 records reviewed (#1).</p> <p>Findings</p> <p>1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1 with physical therapist, (PT) Employee C.</p> <p>At 2:20 PM, the PT, Employee C indicated he had called the Registered Nurse, (RN) Employee D, on Monday 7/21/14 about the open wound on the patient's right lower leg. The wound was from radiation related to cancer. The patient indicated the pain is 3-4 on a scale of 1-10 and quite bothersome. The patient indicated the RN, Employee D, had not called the patient nor had made a visit to assess the patient. The wound is approximately 1.5 in x 1.5 and circular in nature. It is impossible to gauge anything else as the patient had applied Silver Sulfadiazine 1%, from the nursing home stay in May, into the wound. The wound was oozing a pink color liquid that had drained approximately 1.5 inches down the patient's leg and soiled the top of the sock.</p>	G000175	<p>Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff on the necessity of physician notification of change in patient's condition that may require updates to the plan of care. In addition, 100% of all new clinical records post inservice were audited with 100% compliance achieved. 10% of all clinical records will then be audited quarterly. Monitoring will occur by auditing 100% of all new clinical records after inservicing, then 10% of all clinical records quarterly for 1 year to ensure compliance. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	08/29/2014

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	<p>The patient indicated the RN, Employee C, had been informed of a place starting on the left lower leg. The patient indicated the RN had not acted on the information.</p> <p>2. On 7/28/14 at 11 AM, Employee D, Registered Nurse, indicated not being able to visit the patient after she was told about the new wound on the left leg due to commitments with another job. "I was booked and could not go," she said. She also indicated the patient had an appointment pending with the oncologist for wound care on July 24th. She did not call the primary physician and was waiting for the patient to see the oncologist.</p> <p>3. An agency policy titled "Admission criteria" with no date stated, "The agency will admit clients ... to comply with government regulations ... there must be a reasonable expectation that the client's needs can be met in the home setting through the Agency's programs and services."</p>				

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G000176	<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. Based on clinical record and agency policy review and interview, the agency failed to ensure all personnel communicated and coordinated services to support the plan of care in 2 (# 7 and 10) of 12 records reviewed.</p> <p>The findings include</p> <p>1. Clinical record # 7, start of care 6/21/14, included a plan of care for the certification period of 6/21/14 - 8/19/14 with orders for skilled nursing, occupational therapy and physical therapy. The clinical record failed to show that any coordination of care had occurred between these services to support the patient's plan of care. Skilled nursing visits were on 6/21/14, 6/25/14, 7/1/14, 7/4/14, 7/8/14, 7/15/14, and 7/22/14. Occupational therapy visits were on 6/27/14, 7/2/14, 7/4/14, 7/18/14, and 7/19/14. Physical therapy visits were on 7/23/14, 6/25/14, 7/2/14, 7/9/14, 7/9/14, 7/11/14, 7/15/14, 7/16/14, and</p>	G000176	<p>Paula Lorance, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff regarding coordination of care between disciplines as defined in Policy #304. In addition, 100% of the deficient records during survey and 100% of all new clinical records post inservice were audited with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will occur by auditing 100% of the deficient records as well as 100% of all new clinical records post inservice. 10% of all clinical records will then be audited monthly for 1 year to ensure proper coordination of care between disciplines is occurring. Paula Lorance, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	08/29/2014

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	<p>7/18/14.</p> <p>On 7/28/14 at 12:30 PM, Employee B, vice president of operations, indicated there was no coordination of care between these services caring for the patient.</p> <p>2. Clinical record #10, start of care 5/3/14, included a plan of care for the certification period of 5/3/14 - 7/1/14 with orders for occupational therapy and physical therapy. There was no documentation to show that the physical therapist and occupational therapist had communicated and coordinated services to support the patient's plan of care. Physical therapy visits occurred on 5/3/14, 5/8/14, 5/14/14, 5/17/14, 5/24/14. Occupational therapy visits occurred on 5/9/14, 5/15/14, 5/17/14, 5/19/14, 5/22/14, 5/30/14, and 5/31/14.</p> <p>On 7/28 at 4:50 PM, Employee B indicated there was no coordination of care between the services caring for this patient.</p> <p>3. The agency policy titled "Coordination of care" with a date of June 2012 stated, "A registered nurse, physical therapist, or speech therapist will be assigned to coordinate the care of each client from admission to discharge.</p>				

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G000207	<p>This RN, PT, or ST will be responsible for coordination of the home care team's communication and the client's plan of care ... to comply with government regulations ... to facilitate continuity of care; to assure appropriate care."</p> <p>484.36(a)(2) HHA TRAINING - CONDUCT A home health aide training program may be offered by any organization except an HHA that, within the previous two years, has been found:</p> <ul style="list-style-type: none"> - Out of compliance with requirements of this paragraph (a) or paragraph (b) of this section - To permit an individual that does not meet the definition of "home health aide" as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers) - Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State) - Has been assessed a civil monetary penalty of not less than \$5,000 as an intermediate sanction - Has been found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee the management of the HHA - Has had all or part of its Medicare payments suspended <p>Further, under any Federal or State law within the 2-year period beginning on</p>			

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	<p>October 1, 1988:</p> <ul style="list-style-type: none"> - Has had its participation in the Medicare program terminated - Has been assessed a penalty of not less than \$5,000 for deficiencies in Federal or State standards for HHAs - Was subject to a suspension of Medicare payments to which it otherwise would have been entitled; - Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients - Was closed or had its residents transferred by the State. <p>Based on document and personnel file review and interview, the agency failed to ensure Home Health Aide (HHA) competency testing was not performed by the agency during the two years the agency was precluded from providing its own HHA competency testing for 2 of 2 HHA hired (J and R) within the two year preclusion time frame with the potential to affect all the HHA services provided by the agency.</p> <p>Findings include</p> <p>1. The file for employee J, date of hire 2/1/13, first patient contact date 2/25/13, contained a Home Health Aide Competency Assessment dated on 2/20/13 and signed by Employee J and Employee U, Registered Nurse (RN).</p>	G000207	<p>A contracted, nonagency RN will be hired by the agency to competency all aides at time of hire and annually. The agency will still be responsible for all inservicing requirements. Monitoring will occur at time of hire and annual competency evaluation will be performed by a nonagency RN for a period of 2 years. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	08/29/2014

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	<p>2. The file for employee R, date of hire 3/1/13 and first patient contact date 3/21/13 , contained a Home Health Aide Competency Assessment dated 3/21/13 and signed by Employee R and Employee X, RN.</p> <p>3. On 7/29/14 at 1:15 PM, Employee A, director of nursing, indicated the HHAs were competencied by past employees and not by a contract nurse as required by the preclusion from providing the agency's own HHA competency.</p> <p>4. Survey documentation from a federal recertification / state relicensure on August 16 - 23, 2011, evidenced that VNA Healthtrends was found out of compliance with the Conditions of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision and was precluded form providing a home health aide training and competency program beginning August 23, 2011, to August 23, 2013.</p>			

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G000242	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM</p> <p>Based on administrative record and agency policy review and interview, it was determined the agency failed to have an annual evaluation of the agency's total program that included policy and administrative review (see G 244); failed to ensure an annual review was completed that assessed the extent to which the agency's program is appropriate, adequate, effective, and efficient (see G 245); failed to have an annual evaluation of the agency's total program (see G 246); failed to have an annual evaluation of the agency's total program that was maintained as a separate administrative record (see G 247); failed to ensure an annual evaluation was completed that included a review of policies and administrative practices to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient (see G 248); and failed to ensure mechanisms were in place for the collection of data for the annual evaluation (see G 249).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the</p>	G000242	<p>A Professional Advisory Committee meeting will be held by 8/29/2014 and at least annually thereafter. Monitoring will occur as part of the annual Board of Directors' meeting. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure this deficiency is corrected and does not recur.</p>	08/29/2014

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G000244	<p>condition 42 CFR 484.52 Evaluation of the Agency's Program.</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review.</p> <p>Based on agency policy and document review and interview, the agency failed to have an annual evaluation of the agency's total program for 1 of 1 agency that included policy and administrative review.</p> <p>Findings</p> <p>1. Review of agency documents failed to evidence the agency had completed an annual evaluation that included an overall</p>	G000244	<p>A Professional Advisory Committee meeting will be held at least annually to review programs, policies, performance improvement and outcomes data. In addition, performance data and outcomes will be submitted to corporate leadership for review on a quarterly basis. Monitoring of performance data and outcomes analysis will occur quarterly and ongoing. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these</p>	08/29/2014

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	<p>policy and administrative review.</p> <p>2. On 7/29/14 at 3:30 PM, Employee B, the vice president of operations, indicated the corporate Professional advisory committee / senior management met every month to discuss corporate and agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio.</p> <p>3. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and Indiana. However, there was not any professional advisory group solely for this agency.</p> <p>4. The agency policy titled "Designing Process" with a date of June 2014 stated, "Performance improvement design criteria shall be used as a guide for operational decision making ... the leaders of the organization shall ensure that the above criteria are built into the organization's resource allocation for new products and services. The leaders of the organization shall oversee the planning and design of new processes."</p> <p>5. The agency policy titled "Performance Improvement Process" with a date of June 2014 stated, "The Performance Improvement process is a systematic evaluation to ensure excellence in the</p>		corrective actions to ensure these deficiencies are corrected and does not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157569	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER VNA HEALTHTRENDS			STREET ADDRESS, CITY, STATE, ZIP CODE 732 E US HWY 30 SCHERERVILLE, IN 46375		
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G000245	<p>Home Health Care agency ... consistency with clinical and regulatory guidelines."</p> <p>6. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual performance improvement evaluation report will be prepared during the fourth quarter of the year and integrated into the agency - wide annual evaluation report."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM</p>				

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	<p>The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.</p> <p>Based on agency policy and document review and interview, the agency failed to ensure an annual review was completed that assessed the extent to which the agency's program is appropriate, adequate, effective, and efficient for 1 of 1 agency.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence the agency had completed an annual evaluation that assessed the extent to which the agency's program is appropriate, adequate, effective, and efficient. 2. On 7/29/14 at 3:30 PM, Employee B, the vice president of operations, indicated the corporate Professional advisory committee / senior management met every month to discuss corporate and agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio. 3. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and Indiana. However, there was not any professional advisory group solely for 	G000245	<p>A Professional Advisory Committee meeting will be held at least annually to review programs, policies, performance improvement and outcomes data. In addition, performance data and outcomes will be submitted to corporate leadership for review on a quarterly basis. Monitoring of performance data and outcomes analysis will occur quarterly and ongoing. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure these deficiencies are corrected and does not recur.</p>	08/29/2014

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	<p>this agency.</p> <p>4. The agency policy titled "Designing Process" with a date of June 2014 stated, "Performance improvement design criteria shall be used as a guide for operational decision making ... the leaders of the organization shall ensure that the above criteria are built into the organization's resource allocation for new products and services. The leaders of the organization shall oversee the planning and design of new processes."</p> <p>5. The agency policy titled "Performance Improvement Process" with a date of June 2014 stated, "The Performance Improvement process is a systematic evaluation to ensure excellence in the Home Health Care agency ... consistency with clinical and regulatory guidelines."</p> <p>6. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early</p>			

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G000246	<p>identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual performance improvement evaluation report will be prepared during the fourth quarter of the year and integrated into the agency - wide annual evaluation report."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. Based on agency policy and document review and interview, the agency failed to have an annual evaluation of the agency's total program for 1 of 1 home health agency.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence the agency had completed an annual evaluation. 2. On 7/29/14 at 3:30 PM, Employee B, 	G000246	<p>A Professional Advisory Committee meeting will be held at least annually to review programs, policies, performance improvement and outcomes data. In addition, performance data and outcomes will be submitted to corporate leadership for review on a quarterly basis. Monitoring of performance data and outcomes analysis will occur quarterly and ongoing. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these</p>	08/29/2014

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	<p>the vice president of operations, indicated the corporate Professional advisory committee / senior management met every month to discuss corporate and agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio.</p> <p>3. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and Indiana. However, there was not any professional advisory group solely for this agency.</p> <p>4. The agency policy titled "Designing Process" with a date of June 2014 stated, "Performance improvement design criteria shall be used as a guide for operational decision making ... the leaders of the organization shall ensure that the above criteria are built into the organization's resource allocation for new products and services. The leaders of the organization shall oversee the planning and design of new processes."</p> <p>5. The agency policy titled "Performance Improvement Process" with a date of June 2014 stated, "The Performance Improvement process is a systematic evaluation to ensure excellence in the Home Health Care agency ... consistency with clinical and regulatory guidelines."</p>		corrective actions to ensure these deficiencies are corrected and does not recur.	

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G000247	<p>6. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual performance improvement evaluation report will be prepared during the fourth quarter of the year and integrated into the agency - wide annual evaluation report."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are maintained</p>			

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	<p>separately as administrative records.</p> <p>Based on agency policy and document review and interview, the agency failed to have an annual evaluation of the agency's total program that was maintained as a separate administrative record for 1 of 1 agency.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence the agency had completed an annual evaluation that was maintained as a separate administrative record. 2. On 7/29/14 at 3:30 PM, Employee B, the vice president of operations, indicated the corporate Professional advisory committee / senior management met every month to discuss corporate and agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio. 3. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and Indiana. However, there was not any professional advisory group solely for this agency. 4. The agency policy titled "Designing Process" with a date of June 2014 stated, "Performance improvement design criteria shall be used as a guide for 	G000247	<p>A Professional Advisory Committee meeting will be held at least annually to review programs, policies, performance improvement and outcomes data. In addition, performance data and outcomes will be submitted to corporate leadership for review on a quarterly basis. Monitoring of performance data and outcomes analysis will occur quarterly and ongoing. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure these deficiencies are corrected and does not recur.</p>	08/29/2014

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	<p>operational decision making ... the leaders of the organization shall ensure that the above criteria are built into the organization's resource allocation for new products and services. The leaders of the organization shall oversee the planning and design of new processes."</p> <p>5. The agency policy titled "Performance Improvement Process" with a date of June 2014 stated, "The Performance Improvement process is a systematic evaluation to ensure excellence in the Home Health Care agency ... consistency with clinical and regulatory guidelines."</p> <p>6. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual</p>			

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G000248	<p>performance improvement evaluation report will be prepared during the fourth quarter of the year and integrated into the agency - wide annual evaluation report."</p> <p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. Based on agency policy and document review and interview, the agency failed to ensure an annual evaluation was completed that included a review of policies and administrative practices to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient for 1 of 1 agency.</p> <p>Findings</p> <p>1. Review of agency documents failed to evidence the agency had completed an annual evaluation that included a review of policies and administrative practices to</p>	G000248	<p>A Professional Advisory Committee meeting will be held at least annually to review programs, policies, performance improvement and outcomes data. In addition, performance data and outcomes will be submitted to corporate leadership for review on a quarterly basis. Monitoring of performance data and outcomes analysis will occur quarterly and ongoing. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure these deficiencies are corrected and does not recur.</p>	08/29/2014

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	<p>determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient.</p> <p>2. On 7/29/14 at 3:30 PM, Employee B, the vice president of operations, indicated the corporate Professional advisory committee / senior management met every month to discuss corporate and agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio.</p> <p>3. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and Indiana. However, there was not any professional advisory group solely for this agency.</p> <p>4. The agency policy titled "Designing Process" with a date of June 2014 stated, "Performance improvement design criteria shall be used as a guide for operational decision making ... the leaders of the organization shall ensure that the above criteria are built into the organization's resource allocation for new products and services. The leaders of the organization shall oversee the planning and design of new processes."</p> <p>5. The agency policy titled "Performance Improvement Process" with a date of June 2014 stated, "The Performance</p>			

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G000249	<p>Improvement process is a systematic evaluation to ensure excellence in the Home Health Care agency ... consistency with clinical and regulatory guidelines."</p> <p>6. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual performance improvement evaluation report will be prepared during the fourth quarter of the year and integrated into the agency - wide annual evaluation report."</p> <p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.</p>			

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	<p>Based on agency policy review and interview, the agency failed to ensure mechanisms were in place for the collection of data for the annual evaluation for 1 of 1 agency.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence the agency had mechanisms in place for the collection of data for the annual evaluation. 2. On 7/29/14 at 3:30 PM, Employee B, the vice president of operations, indicated the corporate Professional advisory committee / senior management met every month to discuss corporate and agency concerns for all the agencies it headed in Illinois, Indiana, and Ohio. 3. A review of corporate documents showed that professional personnel met to discuss agencies in Ohio, Illinois and Indiana. However, there was not any professional advisory group solely for this agency. 4. The agency policy titled "Designing Process" with a date of June 2014 stated, "Performance improvement design criteria shall be used as a guide for operational decision making ... the leaders of the organization shall ensure 	G000249	A Professional Advisory Committee meeting will be held by 8/29/2014 and at least annually thereafter. Any notable performance improvement trends will be reviewed at that time. Monitoring will occur as part of the annual Board of Directors' meeting. Barbara Hills, RN, Vice President of Clinical Services will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.	08/29/2014			

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	<p>that the above criteria are built into the organization's resource allocation for new products and services. The leaders of the organization shall oversee the planning and design of new processes."</p> <p>5. The agency policy titled "Performance Improvement Process" with a date of June 2014 stated, "The Performance Improvement process is a systematic evaluation to ensure excellence in the Home Health Care agency ... consistency with clinical and regulatory guidelines."</p> <p>6. The agency policy titled "Performance Improvement Reports" with a date of June 2014 stated, "Performance Improvement reports will be responsible and will be the responsibility of all directors of nursing and they will be held accountable for measuring data and preparing reports for agency leadership on an ongoing basis ... Purpose: comply with government regulations ... to facilitate early identification of problems before complications; to ensure early identification of successes to be continued, replicated, or improved ... the leadership - agency governing body and PAC [professional advisory committee] will set performance improvement priorities for the agency ... an annual performance improvement evaluation report will be prepared during the fourth</p>			

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N000000	quarter of the year and integrated into the agency - wide annual evaluation report."			
	This was a home health state relicensure survey. Survey date: 7/23/14 - 7/29/14 Facility # 004608 Medicaid # 200538740 Surveyors: Ingrid Miller, RN, PHNS, Lead Surveyor Susan E. Sparks, RN, MAE, PHNS 507 skilled unduplicated patients for past year Quality Review: Joyce Elder, MSN, BSN, RN August 5, 2014	N000000		
N000456	410 IAC 17-12-1(e) Home health agency			

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	<p>administration/management</p> <p>Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following:</p> <p>(1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care.</p> <p>(2) Resolve identified problems.</p> <p>(3) Improve patient care.</p> <p>Based on document review and interview, the agency failed to ensure the ongoing quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolved identified problems, and improve patient care for 1 of 1 agency.</p> <p>Findings</p> <p>1. On 7/29/14 at 3:30 PM, Employee B, vice president of operations, indicated the quality assurance program used data from CMS and clinical records. The outcomes are from CMS. There are daily electronic quality assurance documents sent to staff from Illinois and Indiana regarding oasis questions for the quality assurance program. Chart review is done in the agency. There was no written plan for the quality assurance program.</p> <p>2. A review of agency documents failed to evidence a quality assurance program</p>	N000456	<p>Performance improvement reports are generated and analyzed in the Schererville office monthly. This data is then submitted quarterly to corporate leadership for analysis and review and is also presented in the Professional Advisory Committee meeting. The information provided is used to evaluate the quality of care provided and determine ongoing agency programs. Monitoring will occur monthly by the DON and Administrator and quarterly with submission of data to the Vice President of Clinical Services. Outcomes that require immediate attention will be reported to the Administrator by the DON and forwarded to corporate leadership for review. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure these deficiencies are corrected and does not recur.</p>	08/29/2014

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N000458	<p>that addressed identified problems and improved patient care.</p> <p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on personnel file and policy review and interview, the agency failed to ensure the personnel policies were followed in 5 of 20 employee records reviewed (Employee E, J, L, O , R).</p> <p>Findings</p> <p>1. Employee E, occupational therapist, date of hire 3/10/14 and first patient contact 3/10/14, failed to evidence a job description had been completed upon</p>	N000458	<p>1. All outstanding employee paperwork will be obtained and placed in the employee personnel files. In addition, all personnel files will be audited to ensure compliance with applicable requirements. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and</p>	08/29/2014	

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	<p>hire.</p> <p>2. Employee J, home health aide, date of hire 2/1/13 and first patient contact 2/25/13, failed to evidence the aide had been verified as in good standing on the state aide registry.</p> <p>3. Employee L, home health aide, date of hire 5/22/14 and first patient contact 6/11/14, failed to evidence a job description had been signed at the time of hire. The file also evidenced the home health aide had not been verified as in good standing on the state aide registry.</p> <p>4. Employee O, occupational therapist, date of hire 1/10/08 and first patient contact 3/20/10, failed to evidence an annual performance evaluation had been completed.</p> <p>5. Employee R, home health aide, date of hire 3/1/13 and first patient contact 3/2/13, failed to evidence the aide had been verified as in good standing on the state aide registry.</p> <p>6. On 7/29/14 at 4:05 PM, Employee V, human resources, indicated the personnel files were not complete.</p> <p>7. The agency policy titled "Employee Handbook" with a date of November</p>		<p>does not recur. 2. The state aide registry will be checked annually to ensure that aides are registered as both certified nurses' aides and home health aides. In addition, policy #913 has been reviewed and revised to include home health aide services. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 3. All licensed professional staff will provide proof of necessary credentials and sign a job description at time of hire. Monitoring will occur by auditing the employee personnel file at time of hire, then quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 4. The professional licenses of all field staff will be verified annually. Policy #909 has been reviewed and revised to include verification of licensure for all professional staff annually. Monitoring will occur by verifying all professional licenses at time of hire, upon license renewal, then quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be</p>		

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	<p>2012 stated, "The agency will have written competencies for field providers ... staff who must have a licensure and / or certification in order to provide proof of necessary credentials at the time of hire and annually ... Additional formal performance reviews are conducted on the employee anniversary date annually."</p> <p>8. The agency policy titled "Job descriptions" with a date of June 2012 stated, "There will be a job description for each employee position that states qualifications, defines roles, and list responsibilities."</p> <p>9. The agency policy titled "Employee evaluation Performance Appraisal" with a date of June 2012 stated, "Agency staff may receive a written evaluation after 90 days as indicated and annually .. to comply with government regulations."</p> <p>10. The agency policy titled "CNA services" with a review date of June 2012 stated, "CNA services will be provided to clients throughout this agency in compliance with federal and state regulations." (There was no policy in the agency covering home health aide services.)</p>		<p>responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur. 5. All performance reviews will be conducted annually. Monitoring will occur by auditing the employee personnel files quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and does not recur.</p>	

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N000470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and review of policies and procedures, the agency failed to ensure registered nurses (RN) provided services in accordance with agency policy in 2 of 2 home visit observations (Patients #4 and #6) with a registered nurse (Employee I and Employee P).</p> <p>The findings include</p> <ol style="list-style-type: none"> On 7/25/15 at 7 AM, Employee P, RN, was observed to don gloves and remove the wound dressing from patient # 4's abdominal wound and measure the wound. He did not remove his gloves after removing the old dressing or wash his hands before he proceeded to clean the wound area and apply the clean dressing for the wound vac treatment. He discarded all supplies and removed his gloves and then washed his hands. On 7/25/14 at 9 AM, Employee I, RN, was observed at a home visit with patient #6. Employee I was observed to 	N000470	<p>Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will inservice all nursing staff on Infection Control, Handwashing, Standard Precautions and Bag Technique. Monitoring will occur with on-site supervisory evaluations and competencies annually. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p>	08/29/2014

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	<p>wash her hands and don clean gloves and then place all dressing supplies on the patient's living room floor. There was no barrier between these supplies, which included a Genadyne Foam Kit Thin Medium, 4 gauze dressings, clean gloves, skin preparation pad, and a saline wash bottle, and the floor. She removed the old dressing from the patient's left foot and discarded her gloves. She did not wash her hands. She applied clean gloves and dressed the wound and applied the wound vac.</p> <p>3. The agency policy titled "Hand hygiene" with a date revised of June 2012 stated, "Field providers will wash hands ... after removing soiled gloves."</p> <p>4. The agency policy titled "Standard Precautions" with a revised date of June 2012 stated, "Handwashing with an antibacterial soap, water, and hand sanitizer ... will be done before putting on protective gloves; B. upon removal of protective gloves."</p> <p>5. The agency policy titled "Bag contents and technique" with a revised date of June 2012 stated, "The floor is a grossly contaminated area ... open bag and remove supplies. Place them on a clean work area with appropriate barrier paper or drape." on observation, interview,</p>			

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N000472	<p>and review of policies and procedures, the agency</p> <p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on document review and interview, the agency failed to ensure the ongoing quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolved identified problems, and improve patient care for 1 of 1 agency.</p> <p>Findings</p> <p>1. On 7/29/14 at 3:30 PM, Employee B, vice president of operations, indicated the</p>	N000472	<p>Performance improvement reports are generated and analyzed in the Schererville office monthly. This data is then submitted quarterly to corporate leadership for analysis and review and is also presented in the Professional Advisory Committee meeting. The information provided is used to evaluate the quality of care provided and determine ongoing agency programs. Monitoring will occur monthly by the DON and Administrator and quarterly with submission of data to the Vice President of Clinical Services. Outcomes that require immediate attention will be reported to the Administrator by</p>	08/29/2014			

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N000484	<p>quality assurance program used data from CMS and clinical records. The outcomes are from CMS. There are daily electronic quality assurance documents sent to staff from Illinois and Indiana regarding oasis questions for the quality assurance program. Chart review is done in the agency. There was no written plan for the quality assurance program.</p> <p>2. A review of agency documents failed to evidence a quality assurance program that addressed identified problems and improved patient care.</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record and agency policy review and interview, the agency failed to ensure all personnel communicated and coordinated services to support the plan of care in 2 (# 7 and 10) of 12 records reviewed creating the potential to affect all of the agency's 204 current patients.</p>	N000484	<p>the DON and forwarded to corporate leadership for review. Barbara Hills, RN, Vice President of Clinical Services, Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure these deficiencies are corrected and does not recur.</p> <p>Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff regarding coordination of care between disciplines as defined in Policy #304. In addition, 100% of the deficient records during survey and 100% of all new clinical records post inservice were audited with 100% compliance achieved. 10% of all clinical records will be then be</p>	08/29/2014

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	<p>The findings include</p> <p>1. Clinical record # 7, start of care 6/21/14, included a plan of care for the certification period of 6/21/14 - 8/19/14 with orders for skilled nursing, occupational therapy and physical therapy. The clinical record failed to show that any coordination of care had occurred between these services to support the patient's plan of care. Skilled nursing visits were on 6/21/14, 6/25/14, 7/1/14, 7/4/14, 7/8/14, 7/15/14, and 7/22/14. Occupational therapy visits were on 6/27/14, 7/2/14, 7/4/14, 7/18/14, and 7/19/14. Physical therapy visits were on 7/23/14, 6/25/14, 7/2/14, 7/9/14, 7/9/14, 7/11/14, 7/15/14, 7/16/14, and 7/18/14.</p> <p>On 7/28/14 at 12:30 PM, Employee B, vice president of operations, indicated there was no coordination of care between these services caring for the patient.</p> <p>2. Clinical record #10, start of care 5/3/14, included a plan of care for the certification period of 5/3/14 - 7/1/14 with orders for occupational therapy and physical therapy. There was no documentation to show that the physical therapist and occupational therapist had</p>		<p>audited monthly. Monitoring will occur by auditing 100% of the deficient records and 100% of all new clinical records post inservice by 8/29/14, then 10% of all clinical records will be audited monthly for 1 year to ensure proper coordination of care between disciplines is occurring. Paula Lorance, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	

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N000518	<p>communicated and coordinated services to support the patient's plan of care. Physical therapy visits occurred on 5/3/14, 5/8/14, 5/14/14, 5/17/14, 5/24/14. Occupational therapy visits occurred on 5/9/14, 5/15/14, 5/17/14, 5/19/14, 5/22/14, 5/30/14, and 5/31/14.</p> <p>On 7/28 at 4:50 PM, Employee B indicated there was no coordination of care between the services caring for this patient.</p> <p>3. The agency policy titled "Coordination of care" with a date of June 2012 stated, "A registered nurse, physical therapist, or speech therapist will be assigned to coordinate the care of each client from admission to discharge. This RN, PT, or ST will be responsible for coordination of the home care team's communication and the client's plan of care ... to comply with government regulations ... to facilitate continuity of care; to assure appropriate care."</p> <p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced</p>			

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	<p>directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, in 12 of 12 records reviewed (#1 - 12).</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The admission book given to the patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana advanced directives in the admission folder that was distributed to the patients at the start of care (SOC). 2. On 7/24/14 at 3:15 PM, the vice president of operations, Employee B, indicated the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013) in patient # 1 - 12's home admission books and all the patients of the agency needed to receive the updated advanced directives. 3. Clinical record #1, SOC 7/2/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed 	N000518	<p>The revised 7/1/2013 State of Indiana Advanced Directives document has been added to all admission packets as of 7/29/2014. In addition, the admission packet will be audited quarterly to ensure compliance with the most current Advanced Directives document. The Indiana state regulatory website will also be checked monthly for ongoing updates to this document. An admission packet audit tool will be developed to ensure compliance. Monitoring will occur quarterly and ongoing. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and do not recur.</p>	08/29/2014

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	<p>that the document was received on the SOC date.</p> <p>4. Clinical record #2, SOC 7/10/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>5. Clinical record #3, SOC 7/5/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>6. Clinical record #4, SOC 7/2/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>7. Clinical record #5, SOC 7/19/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>8. Clinical record #6, SOC 7/12/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced</p>			

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	<p>Directives document. The patient signed that the document was received on the SOC date.</p> <p>9. Clinical record #7, SOC 6/21/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>10. Clinical record #8, SOC 1/28/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>11. Clinical record #9, SOC 11/14/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>12. Clinical record #10, SOC 5/3/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>13. Clinical record #11, SOC 6/29/14, failed to contain an updated July 1, 2013,</p>			

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N000522	<p>version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>14. Clinical record #12, SOC 6/21/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>15. The agency document titled "Statement of Indiana Law on Advance Directives" with no effective date stated, "The Statement of Indiana Law on Advance Directives has been written in fulfillment of the Omnibus Budget Reconciliation Act of [Obra '90] requirement that the State prepare such a statement to be distributed by providers ... It is agency's policy to recognize the rights of its clients to make informed decisions about their medical care ... it is our policy to comply with the applicable law."</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</p>			

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	<p>podiatrist, as follows: Based on clinical record review, policy review, observation, and interview, the agency failed to ensure care visits and treatments were provided as ordered on the plan of care for 5 of 12 records reviewed (#3, #4, #6, #7, #10).</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) 7/5/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/5/14 - 9/2/14 with orders for skilled nursing to visit four times a week for one week, 3 times a week for 2 weeks, 1 time a week for two weeks, and 1 time every 2 weeks. The skilled nurse was to report a pattern of blood glucose levels over 350 milligram / dl. There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day. The skilled nurse was to perform / instruct / reinforce client / caregiver procedure of wound car to left foot surgical wound three times a week, cleanse with wound cleanser, pat dry. Apply iodoform packing. Cover with dry gauze and abdominal pad. Then secure with kerlix and tape using clean technique. At visits on 7/5/14, 7/9/14, 7/11/14, 7/12/14, 7/14/14, 7/16/14, 7/19/14, and 7/21/14, the skilled nurse</p>	N000522	Paula Lorange, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff on the necessity of following the plan of care. In addition, 100% of all new clinical records post inservice were reviewed with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will occur by auditing 100% of all new clinical records post inservice by 8/29/2014, then 10% of all clinical records will be audited monthly for 1 year to ensure compliance. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	08/29/2014

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NAME OF PROVIDER OR SUPPLIER VNA HEALTHTRENDS	STREET ADDRESS, CITY, STATE, ZIP CODE 732 E US HWY 30 SCHERERVILLE, IN 46375
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	<p>used telfa to dress the wound. The record failed to evidence an order for Telfa to be used to dress the wound.</p> <p>On 7/24/14 at 3:40 PM, Employee B, vice president of operations, indicated that the patient was not taught to keep a blood sugar log and that telfa was not ordered on the plan of care.</p> <p>2. Clinical record #4, SOC 7/2/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/2/14 - 8/30/14 with orders for skilled nursing to visit 2 times a week for one week, 3 times a week for 5 weeks, and 2 times a week for 3 weeks. The skilled nurse was to provide instructions / reinforcement of diabetic care to include diet, skin care, blood glucose testing and the skilled nurse to report a pattern of blood glucose levels greater than 250 mg / dl [milligram / deciliter]. There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day.</p> <p>On 7/24/14 at 4:05 PM, Employee B indicated the patient should have been instructed to keep a blood sugar log to show the blood sugar patterns for this patient.</p>			

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	<p>3. Clinical record #6, SOC 7/12/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/12/14 - 9/9/14 with orders for skilled nursing to visit 1 times a week for 1 week, 3 times a week for 3 weeks, 2 times a week for 5 weeks, and 1 times a week for 1 week. The skilled nurse was to cleanse the wound with wound wash, fill the entire cavity with green vac foam, apply tubing and cover with transparent drape, apply wound vac device at 125 mm [millimeter] continuous. Apply dressing every 48 hours (This should have been three times a week).</p> <p>On 7/25/14 at 9 AM, the registered nurse, Employee I, was observed to apply the wound vac dressing by filling the wound cavity with green foam, cover with transparent drape and apply tubing. After applying the tubing, the nurse added the extra green foam to cushion the wound vac dressing and tubing. There was no order for adding the extra foam over the transparent drape and tubing.</p> <p>4. Clinical record #7, SOC 6/21/14 and diagnosis of surgical hip repair, included a plan of care for the certification period of 6/21/14 - 8/19/14 with orders for the home health aide to visit 2 times a week for two weeks and then one times a week</p>			

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	<p>for two weeks. The aide during visited only once the first week on 6/25/14 and only once the second week on 7/3/14.</p> <p>The plan of care had orders for the occupational therapist to visit one times a week for one week and then two times a week for three weeks and orders for the physical therapist to visit 1 times a week for one week and then two times a week for 5 weeks. The physical therapist only made one visit on July 2nd (the second week). The occupational therapist only made one visit on July 12th (the third week).</p> <p>On 7/28/14 at 12:30 PM, Employee B indicated the home heath aide, occupational therapist, and physical therapist did not visit according to the plan of care.</p> <p>5. Clinical record #10 SOC 5/3/14 and diagnosis of other specified rehabilitation procedure, generalized muscle weakness, depressive disorder, and unspecified peripheral vertigo, included a plan of care with orders for physical therapy orders 1 times a week for 2 weeks, 2 times a week for one week, and 1 times a week and occupational therapy orders for 1 times a week and two times a week for three weeks. The physical therapist visited on 5/3/14, 5/8/14, 5/14/14, 5/24/14. The occupational therapist visited on 5/9/14,</p>			

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	<p>5/15/14, 5/17/14, 5/19/14, 5/22/14, 5/30/14, and 5/31/14. The physical therapist failed to visit the patient twice during the week of 5/11/14 - 5/17/14.</p> <p>On 7/28/14 at 4:50 PM, Employee B indicated the physical therapist did not visit the patient as ordered on the plan of care.</p> <p>6. The agency policy titled "Physician's orders" with a date of June 2012 stated, "Medications and treatments will be administered by agency field provider as ordered by a licensed physician ... all orders must be obtained in compliance with state and / or federal regulations."</p> <p>7. The agency policy titled "Plan of Care" with a date of June 2012 stated, "Home health care services are provided under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of services to the client's condition ... to ensure the provision of quality and legally approved home health care services ... home health care services are provided to clients a. under the general supervision of a physician b. based on a client plan of care established and periodically reviewed by physician to ensure appropriate application of the</p>			

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N000524	<p>services to condition."</p> <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> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities 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> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the plan of care included all the required elements in 4 of 12 records reviewed (#1, 2, 6, 8) with the potential to affect all the patients of the agency.</p> <p>Findings</p>	N000524	Barbara Hill, RN, Vice President of Clinical Services has inserviced the Administrator, Director of Nursing, Documentation Review staff, and all nursing and therapy staff on the necessity of individualizing the plan of care. In addition, 100% of all new clinical records post inservice were audited with 100% compliance achieved. Monitoring will occur by auditing 100% of all new clinical records after	08/29/2014

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	<p>1. Clinical record #1, Start of care (SOC) 7/2/14 and diagnosis of unspecified hypertension, cellulitis, and esophageal reflux, failed to evidence an individualized plan of care for the certification period of 7/2/14 - 8/30/14. The plan of care included orders for physical therapy to instruct safe transfers (bed, bath, toilet, sofa, chair, and commode) using appropriate body mechanics and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). The patient's plan of care evidenced that the patient had a cane, shower / tub equipment, and walker and did not have a sliding board, Hoyer lift, trapeze, and / or wheelchair. The goals for this plan of care did not address care for this patient pertaining to the esophageal reflux diagnosis.</p> <p>On 7/25/14 at 3:45 PM, Employee B, vice president of operations, indicated the plan of care was not individualized and no goals addressed esophageal reflux on the plan of care.</p> <p>2. Clinical record #2, SOC 7/10/14 and diagnosis of after care of hip replacement, failed to evidence that the plan of care for the certification period of 7/10/14 - 9/7/14 that included all the patient's durable medical equipment</p>		<p>inservicing then 10% monthly for 1 year to ensure compliance. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.</p>	

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	<p>including the patients CPAP machine that the patient used each night. The plan of care failed to evidence an individualized plan of care. There were orders for physical therapy to instruct safe transfers (bed, bath, toilet, sofa, chair, and commode) using appropriate body mechanics and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). The patient's plan of care evidenced that the patient had a cane, shower / tub equipment, and walker and did not have a sliding board, Hoyer lift, trapeze, and / or wheelchair.</p> <p>On 7/24/14 at 9:20 AM, patient #2 indicated using a CPAP machine each night for sleep apnea and using a cane and walker for transferring.</p> <p>3. Clinical record #6, SOC 7/12/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/12/14 - 9/9/14. This plan of care included an order that stated, "Skilled nurse to cleanse wound with wound wash. Fill entire cavity with green vac foam. Apply tubing and cover with transparent drape. Apply wound vac at 125 mm [millimeters] pressure continuous. Change dressing every 48 hours."</p> <p>On 7/25/14 at 10 AM, Employee B</p>						

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	<p>indicated the correct order would be to change the wound vac dressing three times a week not every 48 hours.</p> <p>4. Clinical record #8, SOC 1/28/14 and diagnosis of congestive heart failure, included plans of care for the certification periods of 1/18/14 - 3/28/14 with a physician's signature of 3/14/14 and a certification period of 5/28/14 - 7/16/14 with a physician's signature on 7/2/14.</p> <p>On 7/28/14 at 4 PM, Employee B indicated the physician's signatures were late on these plans of care.</p> <p>5. The agency policy titled "Plan of care" with a date of June 2012 state, "Home Health services are provided under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of services to the client's condition. Purpose to ensure the provision of quality and legally approved home health care services ... The client's plan of care is developed by a physician in consultation with field providers B. includes the following ... type of home health care services required ... client's treatment ... client's permitted activity ... rehabilitation and therapy services... medical supplies /</p>			

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N000537	<p>appliances necessary ... review of client's plan of care ... any other appropriate items."</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:</p> <p>Based on clinical record review, policy review, observation, and interview, the agency failed to ensure care by the registered nurse was provided as ordered on the plan of care for 3 of 12 records reviewed (#3, #4, #6,).</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) 7/5/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/5/14 - 9/2/14 with orders for skilled nursing to visit four times a week for one week, 3 times a week for 2 weeks, 1 time a week for two weeks, and 1 time every 2 weeks. The skilled nurse was to report a pattern of blood glucose levels over 350 milligram / dl. There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day. The skilled nurse was</p>	N000537	<p>Paula Lorance, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff on the necessity of following the plan of care. In addition, 100% of all new clinical records post inservice were reviewed with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will occur by auditing 100% of all new clinical records post inservice by 8/29/2014, then 10% of all clinical records will be audited monthly for 1 year to ensure compliance. Paula Lorance, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	08/29/2014

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	<p>to perform / instruct / reinforce client / caregiver procedure of wound car to left foot surgical wound three times a week, cleanse with wound cleanser, pat dry. Apply iodoform packing. Cover with dry gauze and abdominal pad. Then secure with kerlix and tape using clean technique. At visits on 7/5/14, 7/9/14, 7/11/14, 7/12/14, 7/14/14, 7/16/14, 7/19/14, and 7/21/14, the skilled nurse used telfa to dress the wound. The record failed to evidence an order for Telfa to be used to dress the wound.</p> <p>On 7/24/14 at 3:40 PM, Employee B, vice president of operations, indicated that the patient was not taught to keep a blood sugar log and that telfa was not ordered on the plan of care.</p> <p>2. Clinical record #4, SOC 7/2/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/2/14 - 8/30/14 with orders for skilled nursing to visit 2 times a week for one week, 3 times a week for 5 weeks, and 2 times a week for 3 weeks. The skilled nurse was to provide instructions / reinforcement of diabetic care to include diet, skin care, blood glucose testing and the skilled nurse to report a pattern of blood glucose levels greater than 250 mg / dl [milligram / deciliter]. There was no documentation</p>			

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	<p>of interventions for the patient to keep track of the blood sugar levels day by day.</p> <p>On 7/24/14 at 4:05 PM, Employee B indicated the patient should have been instructed to keep a blood sugar log to show the blood sugar patterns for this patient.</p> <p>3. Clinical record #6, SOC 7/12/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/12/14 - 9/9/14 with orders for skilled nursing to visit 1 times a week for 1 week, 3 times a week for 3 weeks, 2 times a week for 5 weeks, and 1 times a week for 1 week. The skilled nurse was to cleanse the wound with wound wash, fill the entire cavity with green vac foam, apply tubing and cover with transparent drape, apply wound vac device at 125 mm [millimeter] continuous. Apply dressing every 48 hours (This should have been three times a week).</p> <p>On 7/25/14 at 9 AM, the registered nurse, Employee I, was observed to apply the wound vac dressing by filling the wound cavity with green foam, cover with transparent drape and apply tubing. After applying the tubing, the nurse added the extra green foam to cushion the</p>			

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N000543	<p>wound vac dressing and tubing. There was no order for adding the extra foam over the transparent drape and tubing.</p> <p>4. The agency policy titled "Physician's orders" with a date of June 2012 stated, "Medications and treatments will be administered by agency field provider as ordered by a licensed physician ... all orders must be obtained in compliance with state and / or federal regulations."</p> <p>5. The agency policy titled "Plan of Care" with a date of June 2012 stated, "Home health care services are provided under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of services to the client's condition ... to ensure the provision of quality and legally approved home health care services ... home health care services are provided to clients a. under the general supervision of a physician b. based on a client plan of care established and periodically reviewed by physician to ensure appropriate application of the services to condition."</p> <p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for</p>			

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	<p>purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified problems with wounds in 1 of 12 records reviewed (#1).</p> <p>Findings</p> <p>1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1 with physical therapist, (PT) Employee C.</p> <p>At 2:20 PM, the PT, Employee C indicated he had called the Registered Nurse, (RN) Employee D, on Monday 7/21/14 about the open wound on the patient's right lower leg. The wound was from radiation related to cancer. The patient indicated the pain is 3-4 on a scale of 1-10 and quite bothersome. The patient indicated the RN, Employee D, had not called the patient nor had made a visit to assess the patient. The wound is approximately 1.5 in x 1.5 and circular in nature. It is impossible to gauge anything else as the patient had applied Silver Sulfadiazine 1%, from the nursing home</p>	N000543	Barbara Hill, RN, Vice President of Clinical Services has inserviced the Administrator, Director of Nursing, Documentation Review staff, and all nursing and therapy staff on the necessity of individualizing the plan of care. In addition, 100% of all new clinical records post inservice were audited with 100% compliance achieved. Monitoring will occur by auditing 100% of all new clinical records after inservicing then 10% monthly for 1 year to ensure compliance. Paula Lorange, RN, Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.	08/29/2014

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NAME OF PROVIDER OR SUPPLIER VNA HEALTHTRENDS			STREET ADDRESS, CITY, STATE, ZIP CODE 732 E US HWY 30 SCHERERVILLE, IN 46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>stay in May, into the wound. The wound was oozing a pink color liquid that had drained approximately 1.5 inches down the patient's leg and soiled the top of the sock.</p> <p>The patient indicated the RN, Employee C, had been informed of a place starting on the left lower leg. The patient indicated the RN had not acted on the information.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified nursing needs in 1 of 12 records reviewed (#1) creating the potential to affect all of the agency's 204 active patients.</p> <p>Findings</p> <p>1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1, with physical therapist, (PT) Employee C.</p> <p>At 2:20 PM, the PT, Employee C indicated he had called the Registered Nurse, (RN) Employee D on Monday 7/21/14 about the open wound on the patient's right lower leg. The wound was from radiation related to cancer. The patient, (#1) indicated the pain is 3-4 and</p>				

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	<p>quite bothersome. The patient #1, indicated the RN, Employee D had not called the patient nor had made a visit to access the patient. The wound is approximately 1.5 in x 1.5 in circular in nature. It is impossible to gauge anything else as the patient had applied Silver Sulfadiazine 1%, from the nursing home stay in May, into the wound. The wound is oozing a pink color liquid that had drained approximately 1.5 in down the patient's leg and soiled the top of the sock.</p> <p>The patient indicated the RN, Employee C had been informed of a place starting on the left lower leg. The patient indicated the RN had not acted on the information.</p> <p>2. On 7/28/14 at 11 AM, Employee D, Registered Nurse, indicated not being able to visit the patient after she was told about the new wound on the left leg due to commitments with another job. "I was booked and could not go," she said. She also indicated the patient had an appointment pending with the oncologist for wound care on July 24th. She did not call the primary physician and was waiting for the patient to see the oncologist.</p> <p>3. An agency policy titled "Admission</p>			

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N000545	<p>criteria" with no date stated, "The agency will admit clients ... to comply with government regulations ... there must be a reasonable expectation that the client's needs can be met in the home setting through the Agency's programs and services."</p> <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. Based on clinical record and agency policy review and interview, the agency failed to ensure all personnel communicated and coordinated services to support the plan of care in 2 (# 7 and 10) of 12 records reviewed.</p> <p>The findings include</p> <p>1. Clinical record # 7, start of care 6/21/14, included a plan of care for the certification period of 6/21/14 - 8/19/14 with orders for skilled nursing, occupational therapy and physical therapy. The clinical record failed to show that any coordination of care had occurred between these services to support the patient's plan of care. Skilled</p>	N000545	Paula Lorance, RN, Administrator and Linda Krippel, RN, DON have inserviced all nursing and therapy staff regarding coordination of care between disciplines as defined in Policy #304. In addition, 100% of the deficient records during survey and 100% of all new clinical records post inservice were audited with 100% compliance achieved. 10% of all clinical records will then be audited monthly. Monitoring will occur by auditing 100% of the deficient records and 100% of all new clinical records post inservice by 8/29/14, then 10% of all clinical records will be audited monthly for 1 year to ensure proper coordination of care between disciplines is occurring. Paula Lorance, RN,	08/29/2014			

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	<p>nursing visits were on 6/21/14, 6/25/14, 7/1/14, 7/4/14, 7/8/14, 7/15/14, and 7/22/14. Occupational therapy visits were on 6/27/14, 7/2/14, 7/4/14, 7/18/14, and 7/19/14. Physical therapy visits were on 7/23/14, 6/25/14, 7/2/14, 7/9/14, 7/9/14, 7/11/14, 7/15/14, 7/16/14, and 7/18/14.</p> <p>On 7/28/14 at 12:30 PM, Employee B, vice president of operations, indicated there was no coordination of care between these services caring for the patient.</p> <p>2. Clinical record #10, start of care 5/3/14, included a plan of care for the certification period of 5/3/14 - 7/1/14 with orders for occupational therapy and physical therapy. There was no documentation to show that the physical therapist and occupational therapist had communicated and coordinated services to support the patient's plan of care. Physical therapy visits occurred on 5/3/14, 5/8/14, 5/14/14, 5/17/14, 5/24/14. Occupational therapy visits occurred on 5/9/14, 5/15/14, 5/17/14, 5/19/14, 5/22/14, 5/30/14, and 5/31/14.</p> <p>On 7/28 at 4:50 PM, Employee B indicated there was no coordination of care between the services caring for this patient.</p>		Administrator and Linda Krippel, RN, DON will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and does not recur.				

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	3. The agency policy titled "Coordination of care" with a date of June 2012 stated, "A registered nurse, physical therapist, or speech therapist will be assigned to coordinate the care of each client from admission to discharge. This RN, PT, or ST will be responsible for coordination of the home care team's communication and the client's plan of care ... to comply with government regulations ... to facilitate continuity of care; to assure appropriate care."				