

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2014
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NAME OF PROVIDER OR SUPPLIER CARDINAL HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 202 MERRILLVILLE, IN 46410
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G000000	<p>This visit was for a federal home health agency recertification survey. This was a partially extended survey.</p> <p>Survey date: December 2 - 5, 2014</p> <p>Facility #: 006655</p> <p>Medicaid #: 200933890</p> <p>Surveyor: Ingrid Miller, RN, PHNS Tameka Warren RN, PHNS</p> <p>Census: 124 skilled unduplicated census for past year</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 15, 2014</p>	G000000		
G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, interview, and</p>	G000121	The Administrator revised all Skilled Visit Notes, Chart Audit,	12/15/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>review of policies, the agency failed to ensure staff had provided services in accordance with agency policies and procedures in 1 of 2 home visit observations (patient #8) with a Registered Nurse (#I) potential to affect any of the active patients cared for by Employee I.</p> <p>Findings</p> <ol style="list-style-type: none"> On 12/4/14 at 12 noon, Employee I, Registered Nurse, entered the home of patient #8 for a home visit. After Employee I entered the house, she placed her nursing bag on the floor of patient #8 home. She did not place a barrier under the bag. On 12/4/14 at 5:25 PM, the administrator indicated the bag was on the floor and this did not follow the agency policy. The agency procedure titled "Nursing Bag Technique" with a date of 2002 stated, "Bag is placed on clean surface. Barrier is utilized as appropriate." The agency policy titled "Nursing Bag" with no date stated, "When in a client's home, place the bag on a clean and dry surface." 		<p>and Employee Checklist forms on 12-04-2014 to include Bag Technique as an item under universal precaution/infection control and said forms were presented to the Surveyors. The Director of Nursing and the Human Resource Manager conducted an In-Service Training regarding the agency policy on Infection Control: Bag Technique on 12-08-2014. On the same day, revised forms were submitted to and approved by the Professional Advisory Group effective immediately. On 12-15-2014, All disciplines were individually instructed regarding changes for strict compliance. Revised Chart Audit form shall be utilized as a tool to audit all clinical charts monthly by the QA Personnel. The Human Resource Manager shall ensure that Infection Control- Bag Technique return demonstration is completed prior to first patient contact, and to include Bag Technique under the topic Infection Control on the Annual Schedule of Monthly In-service Training. It shall be the responsibility of the Administrator/Director of Nursing to make sure full compliance to prevent recurrence of deficiency in the future.</p>	

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G000133	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.</p> <p>Based on observation, document review, and interview, the Administrator failed to be aware of the agency's functions regarding visits scheduled for 1 of 1 home health agency.</p> <p>Findings</p> <ol style="list-style-type: none"> On 12/2/14 at 11:20 AM at the conclusion of the entrance conference, it was requested the agency provide a list of patients scheduled for home visits during the survey. On 12/2/14 at 5 PM, the agency was unable to provide a list of scheduled visits. On 12/2/14 at 5 PM, the administrator indicated there was no schedule readily 	G000133	<p>The Administrator and the Human Resource Manager convened on 12-03-2014, and discussed about the agency policy regarding timely submission of a list of patients scheduled for home visits. Weekly Time Sheet was modified to include a two (2) week projected schedule of patient home visits, and shall be utilized by the Administrator as a locator and a reference as to when & where are the staff, as well as when patients are supposed to be visited. On 12-04-2014, the revised Weekly Time Sheet was presented to and a copy was provided to the Surveyors. On 12-08-2014, revised Weekly Time Sheet was forwarded to and approved by the Professional Advisory Group for immediate implementation. On 12-15-2014, New Weekly time Sheet was distributed to all disciplines, and a one-on-one instruction was provided as to how to complete form appropriately and</p>	12/15/2014

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G000141	<p>available for staff of the agency. This had to be created by calling the staff to see what had been scheduled and looking at the past schedules for visits made.</p> <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 1 of 12 employee records reviewed (K).</p> <p>Findings</p> <p>1. Employee K, Registered Nurse, date of hire 11/1/14 and first patient contact, failed to evidence a competency assessment had occurred that met the requirements of the agency evaluation. A nursing skills evaluation was completed</p>			G000141	<p>accurately; and emphasized that only completed Weekly Time Sheet shall be accepted. To ensure availability of the scheduled visits to the Administrator/Director of Nursing at all times, the Human Resource Manager who is assigned to receive the weekly time sheets from all disciplines, shall monitor timely submission and completeness of the Weekly Time Sheet for 100 % compliance to prevent deficiency from recurring in the future.</p> <p>The Professional Advisory Group met on 12-04-2014, discussed about the agency policy pertaining to Competency Evaluation of Skilled Nursing Staff. A new Skilled Nursing Experience and Skills Inventory was formulated to include essential skills evaluation pertinent to home health services, and a copy was presented to and accepted by the Surveyors. The said form was unanimously approved by the Professional Advisory Group for immediate use on 12-08-2014. The Human Resource Manager shall ensure</p>		12/15/2014

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	<p>on 10/28/14 by Employee K and signed by the administrator on 10/30/14. This nursing skills evaluation evidenced Employee K had demonstrated many nursing skills including wound / skin care, tracheostomy care, and AV Shunt / Fistula Care.</p> <p>2. On 12/2/14 at 3:15 PM, Employee K indicated the first visit she made with patient #4 occurred on her own. She expected the administrator to accompany her but she did not arrive until the end of the visit.</p> <p>3. On 12/3/14 at 4:52 PM, the administrator indicated the nursing skills evaluation completed by Employee K was not demonstrated but more of a skills assessment.</p> <p>4. The agency policy titled "Competency Evaluation of Home Care Staff" with no date stated, "All new employees will be assessed for competency based on the expected requirements for the position ... skills tests including written tests and direct observation of skill will be completed as determined by the agency policies and individual assessments."</p>		<p>that this form is appropriately and accurately completed by all Skilled Nurses at the time of hire, after completion of the probationary period (3 months), and annually thereafter. The Human Resource Manager and the Administrator shall monitor strict compliance to prevent deficiency from recurring in the future. The Administrator and the Human Resource Manager also modified the Employee Checklist to include date, time and name of personnel supervising the first patient visit and should be signed and dated. The revision of the Employee Checklist was approved by the Professional Advisory Group on 12-15-2014 for immediate use. With the use of the revised Employee Checklist, it shall be the responsibility of the Human Resource Manager and the Director of Nursing to ensure first patient contact is performed in the presence of a supervisor, and no new discipline shall be allowed to do visits unless supervised the first time.</p>				

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G000159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included pertinent diagnosis, current medications, and was signed for 2 of 11 records reviewed creating the potential to affect all 51 patients receiving services within the agency. (# 2, #10)</p> <p>Findings</p> <p>1. Clinical record # 2, start of care (SOC) 4/14/14, included a plan of care for the certification period of 10/11/14 - 12/9/14 that failed to list the patient's pacemaker. The plan of care listed Tobramycin dexamethazone eye drops to be administered 1 drop twice a day into both eyes.</p>	G000159	<p>Start of Care/ Resumption of Care and Recertification Oasis forms, as well as the Skilled Nursing visit note were revised to capture at the time of assessment presence of an implant device such as Pacemaker including frequency of monitoring and date last checked. The medication review was also modified on the Skilled Nursing visit note to specify medication changes every visit. Copies of the revised forms were provided to the Surveyors on 12-04-2014. The Professional Advisory Group approved revision of OASIS forms and the Skilled Nursing visit note on 12-08-2014 for immediate implementation. The Human Resource and the Director of Nursing conducted an In-Service Training to all staff regarding policy pertaining to Plan of Care. On 12-15-2014, all Visiting Nurses were individually</p>	12/15/2014

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	<p>a. On 12/4/14 at 2:15 PM, the informal caregiver and patient #2 indicated patient #2 had a pacemaker for over a year and also indicated the eye drops had been discontinued for several months.</p> <p>b. On 12/4/14 at 4:20 PM, the administrator indicated the medication had been discontinued 3 months ago and should not be on the plan of care and the pacemaker should be on the plan of care.</p> <p>2. Clinical record #10, SOC 9/14/14, included a plan of care for the certification period of 9/14/14 - 11/12/14 that failed to evidence a physician's signature.</p> <p>On 12/5/14 at 4:30 PM, the administrator indicated the physician had not signed the plan of care.</p> <p>3. The agency policy titled "Plan of Care" with no date stated, "The plan of care shall be completed in full to include ... medications ... The plan of care / 485 must be signed by the physician and returned to the agency."</p>		<p>instructed regarding the changes made on the forms. All clinical charts shall be audited by the QA personnel monthly using the Chart Audit Tool to ensure 100% compliance. To prevent recurrence of the deficiency, the Director of Nursing shall be responsible in monitoring full compliance. For the Plan of Care not signed by the Physician despite numerous attempts to obtain signature, it was explained to the Surveyors and to the Professional Advisory Group during the survey that patient was referred to the agency on a weekend by the case manager of the hospital with the referring Hospitalist electronic signature, and completed a face-to-face encounter documentation, however, declined to sign the Plan of Care. In compliance with the agency policy, on 12-05-2014, the Professional Advisory Group unanimously agreed to cancel the Start of Care and close the chart; and OASIS coordinator cancelled transmitted SOC OASIS, and the Biller did not submit RAP or final bill as plan of care was not signed. To prevent recurrence of the deficiency, the Referral form was revised to include the date physician was notified and signified his approval to sign documents needed for home health services. The Director of Nursing shall ensure that all documents are signed and dated in a timely manner. Chart audit</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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had alerted the physician to changes that suggested a need to alter the plan of care in 1 (# 8) of 10 active records reviewed creating the potential to affect all of the agency's 51 current patients.</p> <p>The findings include:</p> <p>1. Clinical record #8 included a medication order for Lyrica 75 milligrams 1 tablet by mouth daily for 1 week and then Lyrica 75 milligrams 1 tablet by mouth twice a day with an order date of 10/18/14. There was no documentation in the record the nurse had communicated to the physician about the patient's refusal to take this medication as ordered.</p>	G000176	<p>shall be done by the QA personnel to ensure all documents necessary for start of care are completed at the time of admission, and plan of care is signed in a timely manner.</p> <p>The Director of Nursing and the Human Resource Manager conducted an In-service training on 12-08-2014 regarding agency policy on Interdisciplinary Care Coordination, emphasized need to coordinate client's condition and needs to include refusal to take medications as prescribed by the physician who specifically ordered such medication. Coordination shall be properly documented and completed on the item care coordination on the Skilled Nursing visit note. Agency policy regarding Medication Changes and Medication Profile were also thoroughly discussed; emphasized need to update medication changes on the medication profile both in the patient's home and on the clinical chart in the office. The medication review on the Skilled nursing visit note was modified, revision was presented and approved by the advisory group on 12-08-2014 for immediate</p>	12/15/2014

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G000321	<p>2. On 12/4/14 at 12:15 PM, Employee I, Registered Nurse, set up patient #8's medications for the next week in a medication weekly reminder box. Employee I did not add the medication Lyrica to the box as ordered.</p> <p>3. On 12/4/14 at 12:30 PM, patient #8 indicated not having started this medication due to its side effect of dizziness.</p> <p>4. On 12/5/14 at 9:45 AM, the administrator indicated the nurse had failed to communicate to the physician the patient's noncompliance with this medication.</p> <p>5. The agency policy titled "Skilled Nursing Services" with no date stated, "The registered nurse ... informs the physician and other personnel of changes in the client condition and needs."</p> <p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set.</p> <p>Based on Indiana State Department of Health (ISDH) document review, agency</p>	G000321	<p>implementation. On 12-15-2014, all visiting Nurses were individually instructed on how to appropriately document medication changes. The QA personnel shall perform chart audit to all clinical charts every month and the Director of Nursing shall monitor to ensure 100% compliance to prevent recurrence of deficiency.</p> <p>The OASIS Coordinator, Human Resource Manager and Administrator met on 12-03-2014, discussed measures to ensure</p>	12/08/2014

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	<p>policy review, and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of the completion of the assessment in 9 of 11 records reviewed (1 - 2, 4, 6, 7- 11) creating the potential to affect all of the agency's current skilled patients that require OASIS to be submitted.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An ISDH document dated 11/25/14 evidenced a start of care assessment had been completed on 6/11/14 and a recertification assessment on 8/5/14 for clinical record #1. The document evidenced the start of care assessment had not been transmitted until 7/16/14 and the recertification assessment had not been transmitted until 9/17/14. 2. An ISDH document dated 11/25/14 evidenced a recertification assessment had been completed on 8/8/14 and was not transmitted until 10/23/14 for clinical record #2. 3. An ISDH document dated 11/25/14 evidenced a recertification assessment had been completed on 8/12/14 and not transmitted until 9/17/14 for clinical record #4. 4. An ISDH document dated 11/25/14 		<p>submission, encoding and transmission of OASIS are completed in a timely manner; the Chart Audit form was revised to include item on OASIS transmission before the 30th day from the time OASIS was completed. The Frequency Scheduler Form was modified as well to incorporate a section where OASIS Coordinator can enter exact date OASIS was transmitted. The forms were presented to and approved by the Professional Advisory Group for instantaneous implementation on 12-08-2014. On the same day, the Human Resource Manager and Administrator conducted In-service training regarding agency policy on OASIS Completion and Transmission. To guarantee timely transmission of OASIS, chart audit shall be done by the QA Personnel upon completion and submission of OASIS. The OASIS Coordinator shall enter exact date of transmission on the frequency scheduler and on the Chart Audit Tool. It shall be the responsibility of the Director of Nursing/Administrator to guarantee all OASIS are submitted and transmitted in a timely manner.</p>				

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	<p>evidenced a start of care assessment had been completed on 6/28/14 and not transmitted until 8/18/14 for clinical record #6.</p> <p>5. An ISDH document dated 11/25/14 evidenced a resumption of care assessment after inpatient stay had been completed on 7/29/14 and not transmitted until 9/17/14 for clinical record #7.</p> <p>6. An ISDH document dated 11/25/14 evidenced a resumption of care assessment after inpatient stay had been completed on 8/14/14 and not transmitted until 10/23/14 for clinical record #8.</p> <p>7. An ISDH document dated 11/25/14 evidenced a start of care assessment completed on 6/9/14 and not transmitted until 7/16/14 for record #9. This ISDH document also evidenced a recertification assessment completed on 8/7/14 and not transmitted until 9/17/14 for this record.</p> <p>8. An ISDH document dated 11/25/14 evidenced a start of care assessment completed on 9/14/14 and not transmitted until 10/23/14 for record #10.</p> <p>9. An ISDH document dated 11/25/14 evidenced a recertification assessment completed on 9/13/14 and not transmitted until 10/23/14 for record #11.</p>			

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G000334	<p>10. The agency policy titled "Encoding and Reporting OASIS DATA" with no date stated, "Cardinal Home Health Services, Inc. will electronically report all OASIS data collected in accordance with federal regulations."</p> <p>11. On 12/5/14 at 5 PM, Employee A, human resources; Employee D, the administrator; and Employee E, the oasis coordinator, indicated the transmitting of OASIS data had not occurred within 30 days.</p> <p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on policy and clinical record review and interview, the agency failed to ensure the start of care / comprehensive assessment was complete for 1 of 11 records reviewed (#2).</p> <p>Findings</p> <p>1. Clinical record # 2, start of care 4/14/14, evidenced a comprehensive</p>	G000334	To ensure thorough, well-organized comprehensive and accurate assessment consistent with client's immediate needs particularly on the pacemaker, the Administrator revised the Skilled Nursing Visit note and the SOC/ROC & Recertification OASIS forms to capture the pacemaker frequency of monitoring and the date last checked on 12-04-2014; and a copy was presented to and	12/15/2014

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G000337	<p>assessment was completed on 4/14/14 that lacked a physical assessment of the location of the pacemaker.</p> <p>a. On 12/4/14 at 2:15 PM, the informal caregiver and patient #2 indicated the patient had a pacemaker on the left chest and had forgotten a pacemaker check for the patient that had been scheduled on 12/2/14. The patient indicated having the pacemaker for over a year.</p> <p>b. On 12/4/14 at 4:20 PM, the administrator indicated the comprehensive assessment failed to show the patient had a pacemaker.</p> <p>2. The agency policy titled "Comprehensive Client Assessment" with no date stated, "A thorough, well - organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients in a timely manner ... in addition to general health status / system assessment, the agency comprehensive assessment tool with OASIS will include ... client history."</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify</p>		<p>accepted by the Surveyors. On 12-08-2014, the said forms were submitted to the Professional Advisory Group for thorough deliberation, and merit their approval for immediate implementation. On the same day, an In-service training was conducted by the Human Resource Manager and Administrator regarding agency policy on the Completion of OASIS. On 12-15-2014, all nurses were individually instructed regarding the changes made on the nurse's notes particularly on pacemaker. The Director of Nursing and the QA Personnel shall perform monthly chart audit on all clinical charts to ensure compliance to prevent recurrence of deficiency.</p>	

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N000000	<p>any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review and interview, the agency failed to ensure the medication profile was updated and accurate when there were medication changes for 1 of 11 records reviewed (#2).</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Clinical record # 2, start of care 4/14/14, evidenced a plan of care for the certification period of 10/11/14 - 12/9/14. The medication profile with a review date of 11/25/14 listed Tobramycin dexamethazone eye drops to be administered 1 drop twice a day into both eyes. 2. On 12/4/14 at 2:15 PM, the informal caregiver of patient #2 and patient #2 indicated the Tobramycin eye drops were discontinued months earlier. 3. On 12/4/14 at 4:20 PM, the administrator indicated the medication had been discontinued 3 months ago and should not be on the medication profile. 	G000337	<p>The Administrator revised the medication review on the Skilled Nursing visit to specifically capture medication changes. The revised nurse's visit note was submitted to and approved by the Professional Advisory Group on 12-08-2014 for immediate implementation. The Human Resource Manager and Administrator conducted an In-service training regarding agency policy on Medication Changes and Medication Profile on the same day, specifically emphasized need to complete medication review and update medication profile as needed during each visit. On 12-15-2014, all nurses were individually instructed regarding the changes made particularly on the item-medication changes on their visit notes. The Director of Nursing and the QA Personnel shall perform monthly chart review of all clinical charts to ensure medication review is perform every skilled nursing visit for 100% compliance to avoid recurrence of deficiency.</p>	12/15/2014

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N000444	<p>This visit was for a state home health agency relicensure survey.</p> <p>Survey date: December 2 - 5, 2014</p> <p>Facility #: 006655</p> <p>Medicaid #: 200933890</p> <p>Surveyor: Ingrid Miller, RN, PHNS Tameka Warren RN, PHNS</p> <p>Census: 124 skilled unduplicated census for past year</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 15, 2014</p> <p>410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions.</p> <p>Based on observation, document review,</p>	N000000		12/15/2014
		N000444	The Administrator and the Human Resource Manager convened on	

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	<p>and interview, the Administrator failed to be aware of the agency's functions regarding visits scheduled for 1 of 1 home health agency.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. On 12/2/14 at 11:20 AM at the conclusion of the entrance conference, it was requested the agency provide a list of patients scheduled for home visits during the survey. 2. On 12/2/14 at 5 PM, the agency was unable to provide a list of scheduled visits. 3. On 12/2/14 at 5 PM, the administrator indicated there was no schedule readily available for staff of the agency. This had to be created by calling the staff to see what had been scheduled and looking at the past schedules for visits made. 		<p>12-03-2014, and discussed about the agency policy regarding timely submission of a list of patients scheduled for home visits. Weekly Time Sheet was modified to include a two (2) week projected schedule of patient home visits, and shall be utilized by the Administrator as a locator and a reference as to when & where are the staff, as well as when patients are supposed to be visited. On 12-04-2014, the revised Weekly Time Sheet was presented to and a copy was provided to the Surveyors. On 12-08-2014, revised Weekly Time Sheet was forwarded to and approved by the Professional Advisory Group for immediate implementation. On 12-15-2014, New Weekly time Sheet was distributed to all disciplines, and a one-on-one instruction was provided as to how to complete form appropriately and accurately; and emphasized that only completed Weekly Time Sheet shall be accepted. To ensure availability of the scheduled visits to the Administrator/Director of Nursing at all times, the Human Resource Manager who is assigned to receive the weekly time sheets from all disciplines, shall monitor timely submission and completeness of the Weekly Time Sheet for 100 % compliance to prevent deficiency from recurring in the future.</p>	

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N000458	<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:</p> <ol style="list-style-type: none"> (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. <p>Based on personnel file and policy review and interview, the agency failed to ensure the personnel policies were followed in 1 of 12 employee records reviewed (K).</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Employee K, Registered Nurse, date of hire 11/1/14 and first patient contact, failed to evidence a competency assessment had occurred that met the requirements of the agency evaluation. A nursing skills evaluation was completed on 10/28/14 by Employee K and signed by the administrator on 10/30/14. This nursing skills evaluation evidenced Employee K had demonstrated many 	N000458	The Professional Advisory Group met on 12-04-2014, discussed about the agency policy pertaining to Competency Evaluation of Skilled Nursing Staff. A new Skilled Nursing Experience and Skills Inventory was formulated to include essential skills evaluation pertinent to home health services, and a copy was presented to and accepted by the Surveyors. The said form was unanimously approved by the Professional Advisory Group for immediate use on 12-08-2014. The Human Resource Manager shall ensure that this form is appropriately and accurately completed by all Skilled Nurses at the time of hire, after completion of the probationary period (3 months),	12/15/2014
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	<p>nursing skills including wound / skin care, tracheostomy care, and AV Shunt / Fistula Care.</p> <p>2. On 12/2/14 at 3:15 PM, Employee K indicated the first visit she made with patient #4 occurred on her own. She expected the administrator to accompany her but she did not arrive until the end of the visit.</p> <p>3. On 12/3/14 at 4:52 PM, the administrator indicated the nursing skills evaluation completed by Employee K was not demonstrated but more of a skills assessment.</p> <p>4. The agency policy titled "Competency Evaluation of Home Care Staff" with no date stated, "All new employees will be assessed for competency based on the expected requirements for the position ... skills tests including written tests and direct observation of skill will be completed as determined by the agency policies and individual assessments."</p>		<p>and annually thereafter. The Human Resource Manager and the Administrator shall monitor strict compliance to prevent deficiency from recurring in the future. The Administrator and the Human Resource Manager also modified the Employee Checklist to include date, and name of personnel supervising the first patient visit and should be signed and dated. The revision of the Employee Checklist was approved by the Professional Advisory Group on 12-15-2014 for immediate use. With the use of the revised Employee Checklist, it shall be the responsibility of the Human Resource Manager and the Director of Nursing to ensure first patient contact is performed in the presence of a supervisor, and no new discipline shall be allowed to do visits unless supervised the first time.</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, the agency failed to ensure staff had provided services in accordance with agency policies and procedures in 1 of 2 home visit observations (patient #8) with a Registered Nurse (#I) potential to affect any of the active patients cared for by Employee I.</p> <p>Findings</p> <p>1. On 12/4/14 at 12 noon, Employee I, Registered Nurse, entered the home of patient #8 for a home visit. After Employee I entered the house, she placed her nursing bag on the floor of patient #8 home. She did not place a barrier under the bag.</p> <p>2. On 12/4/14 at 5:25 PM, the administrator indicated the bag was on the floor and this did not follow the agency policy.</p>	N000470	The Administrator revised all Skilled Visit Notes, Chart Audit, and Employee Checklist forms on 12-04-2014 to include Bag Technique as an item under universal precaution/infection control and said forms were presented to the Surveyors. The Director of Nursing and the Human Resource Manager conducted an In-Service Training regarding the agency policy on Infection Control: Bag Technique on 12-08-2014. On the same day, revised forms were submitted to and approved by the Professional Advisory Group effective immediately. On 12-15-2014, All disciplines were individually instructed regarding the changes for strict compliance. Revised Chart Audit form shall be utilized as a tool to review all clinical charts monthly by the QA Personnel. The Human Resource Manager shall ensure that Infection Control- Bag Technique return demonstration is completed prior to first patient contact, and to include Bag Technique under the topic	12/15/2014

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N000524	<p>3. The agency procedure titled "Nursing Bag Technique" with a date of 2002 stated, "Bag is placed on clean surface. Barrier is utilized as appropriate."</p> <p>4. The agency policy titled "Nursing Bag" with no date stated, "When in a client's home, place the bag on a clean and dry surface."</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: (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. Based on clinical record and agency</p>	N000524	Infection Control on the Annual Schedule of Monthly In-service Training. It shall be the responsibility of the Administrator/Director of Nursing to make sure full compliance to prevent recurrence of deficiency in the future. Start of Care/ Resumption of	12/15/2014

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	<p>policy review and interview, the agency failed to ensure plans of care included pertinent diagnosis, current medications, and was signed for 2 of 11 records reviewed creating the potential to affect all 51 patients receiving services within the agency. (# 2, #10)</p> <p>Findings</p> <p>1. Clinical record # 2, start of care (SOC) 4/14/14, included a plan of care for the certification period of 10/11/14 - 12/9/14 that failed to list the patient's pacemaker. The plan of care listed Tobramycin dexamethazone eye drops to be administered 1 drop twice a day into both eyes.</p> <p>a. On 12/4/14 at 2:15 PM, the informal caregiver and patient #2 indicated patient #2 had a pacemaker for over a year and also indicated the eye drops had been discontinued for several months.</p> <p>b. On 12/4/14 at 4:20 PM, the administrator indicated the medication had been discontinued 3 months ago and should not be on the plan of care and the pacemaker should be on the plan of care.</p> <p>2. Clinical record #10, SOC 9/14/14, included a plan of care for the</p>		<p>Care and Recertification Oasis forms, as well as the Skilled Nursing visit note were revised to capture at the time of assessment presence of an implant device such as Pacemaker including frequency of monitoring and date last checked. The medication review was also modified on the Skilled Nursing visit note to specify medication changes every visit. Copies of the revised forms were provided to the Surveyors on 12-04-2014. The Professional Advisory Group approved revision of OASIS forms and the Skilled Nursing visit note on 12-08-2014 for immediate implementation. The Human Resource and the Director of Nursing conducted an In-Service Training to all staff regarding policy pertaining to Plan of Care. On 12-15-2014, all Visiting Nurses were individually instructed regarding the changes made on the forms. All clinical charts shall be audited by the QA personnel monthly using the Chart Audit Tool to ensure 100% compliance. To prevent recurrence of the deficiency, the Director of Nursing shall be responsible in monitoring full compliance. For the Plan of Care not signed by the Physician despite numerous attempts to obtain signature, it was explained to the Surveyors and to the Professional Advisory Group during the survey that patient was referred to the agency on a weekend by the case manager of</p>	

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N000546	<p>certification period of 9/14/14 - 11/12/14 that failed to evidence a physician's signature.</p> <p>On 12/5/14 at 4:30 PM, the administrator indicated the physician had not signed the plan of care.</p> <p>3. The agency policy titled "Plan of Care" with no date stated, "The plan of care shall be completed in full to include ... medications ... The plan of care / 485 must be signed by the physician and returned to the agency."</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing</p>		<p>the hospital with the referring Hospitalist electronic signature, and completed a face-to-face encounter documentation, however, declined to sign the Plan of Care. In compliance with the agency policy, on 12-05-2014, the Professional Advisory Group unanimously agreed to cancel the Start of Care and close the chart; and OASIS coordinator cancelled transmitted SOC OASIS, and the Biller did not submit RAP or final bill as plan of care was not signed. To prevent recurrence of the deficiency, the Referral form was revised to include the date physician was notified and signified his approval to sign documents needed for home health services. The Director of Nursing shall ensure that all documents are signed and dated in a timely manner. Chart audit shall be done by the QA personnel to ensure all documents necessary for start of care are completed at the time of admission, and plan of care is signed in a timely manner.</p>	

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	<p>and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had alerted the physician to changes that suggested a need to alter the plan of care in 1 (# 8) of 10 active records reviewed creating the potential to affect all of the agency's 51 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #8 included a medication order for Lyrica 75 milligrams 1 tablet by mouth daily for 1 week and then Lyrica 75 milligrams 1 tablet by mouth twice a day with an order date of 10/18/14. There was no documentation in the record the nurse had communicated to the physician about the patient's refusal to take this medication as ordered. 2. On 12/4/14 at 12:15 PM, Employee I, Registered Nurse, set up patient #8's medications for the next week in a medication weekly reminder box. Employee I did not add the medication Lyrica to the box as ordered. 3. On 12/4/14 at 12:30 PM, patient #8 indicated not having started this 	N000546	<p>The Director of Nursing and the Human Resource Manager conducted an In-service training on 12-08-2014 regarding agency policy on Interdisciplinary Care Coordination, emphasized need to coordinate client's condition and needs to include refusal to take medications as prescribed by the physician who specifically ordered such medication. Coordination shall be properly documented and completed on the item care coordination on the Skilled Nursing visit note. Agency policy regarding Medication Changes and Medication Profile were also thoroughly discussed; emphasized need to update medication changes on the medication profile both in the patient's home and on the clinical chart in the office. The medication review on the Skilled nursing visit note was modified, revision was presented and approved by the advisory group on 12-08-2014 for immediate implementation. On 12-15-2014, all visiting Nurses were individually instructed on how to appropriately document medication changes. The QA personnel shall perform chart audit to all clinical charts every month, and the Director of Nursing shall monitor to ensure 100% compliance to prevent recurrence of deficiency.</p>	12/15/2014

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	<p>medication due to its side effect of dizziness.</p> <p>4. On 12/5/14 at 9:45 AM, the administrator indicated the nurse had failed to communicate to the physician the patient's noncompliance with this medication.</p> <p>5. The agency policy titled "Skilled Nursing Services" with no date stated, "The registered nurse ... informs the physician and other personnel of changes in the client condition and needs."</p>				