

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157262	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/30/2012
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NAME OF PROVIDER OR SUPPLIER HEALTHMASTERS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WILLOWCREEK ROAD SUITE C PORTAGE, IN 46368
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G0000	<p>This was a federal home health recertification survey. This was a fully extended survey.</p> <p>Survey dates: 8/27/12 - 8/30/12</p> <p>Facility #: 6389</p> <p>Medicaid #: 100450580A</p> <p>Surveyor: Ingrid Miller RN, PHNS</p> <p>Skilled unduplicated census: 32</p> <p>Healthmasters, Inc. is precluded from providing its own home health aide training and competency evaluation for a period of two years beginning September 11, 2012 - September 11, 2014, due to being found out of compliance with the Conditions of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision and 484.36: Home Health Aide Services</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 11, 2012</p>	G0000		

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

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

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G0107	<p>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on policy review, document review, and interview, the agency failed to ensure complaints and the resolution of complaints were documented for 1 of 1 agency with the potential to affect all the agency's patients and family members who complain.</p> <p>Findings</p> <ol style="list-style-type: none"> At an interview with a caregiver for patient #5 on 8/28/12 at 3:15 PM, the caregiver indicated a complaint had been made about a month ago and it had been resolved satisfactorily. On 8/29/12 at 2:20 PM, the complaint log failed to evidence the complaint made by the caregiver of patient #5. On 8/30/12 at 10:10 AM, the complaint documentation was requested again. The administrator indicated the 	G0107	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The complaint for Patient #5 dated 07/09/12 has been completed and is filed in the Complaint Book. The person (caregiver for patient #5) was notified in writing of the results of the investigation and the resolution of the complaint. The complaint was resolved to the caregiver's satisfaction. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. As the result of the findings of this survey, the agency is conducting inservice training for all agency staff 09/18/12 -09/25/12. The agenda includes: Review of 484.10(b)(5) and Agency Policy and Procedure for compliance with 484.10(b)(5).</p> <p>2. A copy of agency's procedure for managing complaints will be issued to patients on admission and reviewed with patient at any time a complaint is made. The agency will at the time of receiving a complaint initiate the agency complaint process per agency policy and procedures to</p>	09/29/2012			

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	<p>complaint documentation was not complete.</p> <p>4. On 8/30/12 at 5:15 PM, the alternate administrator provided the complaint documentation completed on 7/9/12 and reviewed on 7/15/12 with the investigation and resolution and indicated the complaint had been resolved with patient satisfaction. The administrator indicated the complaint log had not been updated because the complaint documentation had been incomplete until this time.</p> <p>5. The agency policy titled "Complaint / Grievance Process" with an effective date of 9/21/07 stated, "The organizational personnel receiving the complaint will discuss verbally and in writing the grievance with the clinical supervisor within 5 days of the alleged grievance. The clinical supervisor will investigate the grievance within 5 days after receipt of such grievance and will make every effort to resolve the grievance to the patient's satisfaction. Response to the patient regarding the complaint will occur within 10 days of receipt ... All complaints will be logged, tracked, trended and filed in the performance improvement office."</p>		<p>include documentation of the: a) receipt of complaints, b) investigation of complaints, c) resolution of complaints, and a copy of the written response to the patient or other person making the complaint to inform of the results of the investigation and the resolution of the complaint, d) a copy of the written response will also be provided to the Director of Nursing. This process will be completed within 10 days of receiving the complaint. 3. A Performance Improvement Team will monitor the existence of complaints weekly and progress to completion of the complaint procedure to ensure the procedure is completed and completed within the time guidelines of the complaint process in compliance with 484.10(b)(5) and Agency Policy and Procedure for compliance with 484.10(b)(5). 4. The Director of Nursing or designee will maintain a complaint log for tracking these procedures.</p> <p>WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and compliance will be maintained.</p>		

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G0121	<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 home visit observation, policy review, and interview, the agency failed to ensure employees followed infection control standards at 1 of 3 home visits with home health aides (Employee H) with the potential to affect all of the patients of the agency receiving home health aide services.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), set up a glucometer with a test strip and also placed a lancet on a paper towel and then proceeded to check the blood sugar by uncapping the lancet and pricking one finger of Patient #1. Employee H placed a blood droplet onto the strip. The glucometer reading for the blood sugar was 73. Then Employee H pulled the used glucometer strip out of the glucometer machine and placed it onto the paper towel with the used lancet and picked these up and threw the paper towel and contents into the household trash. Employee H had gloves on during this</p>			G0121	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. The agency is conducting inservice training for all agency staff 09/18/12- 09/25/12. The agenda includes: a) Review of 484.12(c) Compliance W/ Accepted Professional Standards and Agency Policy and Procedure for compliance with 484.12(c); Infection Control, and c) home health aide care plan and visit report revisions. 2. On 08/28/12 the Director of Nursing contacted the Registered Nurses supervising Employee H, to question their knowledge of Employee H or any other Home Health Aide performing glucometer testing on agency patients and listed their response. The nurses denied any knowledge of this task being performed by any of agencies Home Health Aides. 3. On 08/28/12 The Director of Nursing instructed agency administrative office staff to immediately begin contacting all of its patients who have diabetes and receive home health care services or their caregivers to review procedures regarding any glucometer testing performed in their home and to ask the patient / caregiver to</p>		09/29/2012

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	<p>procedure. Employee A, the administrator / director of nursing, was present while Employee H completed this task.</p> <p>2. On 8/28/12 at 10:30 AM, Employee A indicated the HHA was at risk of a blood borne pathogen due to the completion of the blood sugar check noted above.</p> <p>3. The agency policy titled "Infection Control / Maintenance of Environment / Equipment" with an effective date of 9/13/93 stated, "Client infection control procedures include, but are not limited to, the following: appropriate handling and disposal of waste products."</p>		<p>disclose who performs this procedure in their home and list their response. The response for each was the patient or the caregiver and denied any home health aide involvement in their glucometer testing procedure. 4. On 08/28/12 The Director of Nursing instructed agency staff to immediately begin contacting all of its Home Health Aide staff to review their duties per their scope of practice as it applied to glucometer testing of patient's assigned to them and listed their response. The response was they are not performing glucometer testing on any patients and understand that to be a task they are not allowed to do. 5. On 08/28/12, The Administrator / Director of Nursing conferenced with Employee H regarding unauthorized performing the glucometer testing. Employee H was reinstructed that home health aides are not allowed to perform or assist glucometer testing only write results reported to them. Employee H was advised that the used lancet in the garbage is an infection control issue, was instructed not to add anything else into the container, to store the garbage container in a corner of the room for agency to dispose of the biohazard. The caregiver was instructed to leave the container in the corner. The administrator retrieved the lancet and disposed of lancet in a biohazard sharps container. 6.</p>		

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			<p>Corrective actions are being taken for Employee H. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. As a visual reminder for home health aide duties. A document will be added to the Home clinical record titled 'Task that the Home Health Aides can perform for patients and tasks home health aides cannot perform for patients'. The registered nurse will review this document with all of agency patients and all home health aides during supervisory visits, review of this document will be listed on the Home Health Aide Supervisory Visit Notes. 2. An additional Clinical Nurse Supervisor is in the hiring process to provide increased education and supervision of home health aide care with focus on scope of practice. 3. Glucometer testing is within the scope of practice for nurses. Training to perform blood testing includes specific infection control techniques such as disposal of used lancets at the point of use in an approved sharps container. Infection control education and training for nurses include managing biohazards (sharps and blood). The agency's nurses are the only agency staff authorized to perform blood glucose testing. When the procedure is the agency's responsibility it is a nursing function for which either a registered nurse or a licensed practical nurse is assigned this</p>		

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			duty which will be identified as a technical procedure for the nurse on Plans of Care for all diabetic who have orders for the agency to perform glucometer testing. 4. 10% of clinical records will be audited quarterly by the QA Team for documentation of any task not allowed by the home health aide and the Infection Control Log concurrently for evidence of associated infections. Non-compliance will be reported to the Director of Nursing. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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G0143	<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 review, interview, and policy review, the agency failed to ensure the coordination of care was maintained with other entities that had provided services in 1 of 3 clinical records reviewed (clinical record 5) of patients receiving additional services from other entities.</p> <p>Findings</p> <p>1. Clinical record #5, SOC 7/24/11, included a plan of care for the certification period of 7/18/12 - 9/15/12 that identified the patient received the services of a speech therapist and physical therapist. No documentation was present to show care coordination with these outside entities. This was evidenced by the following:</p> <p style="padding-left: 40px;">A. A nursing note signed by Employee F, Licensed Practical Nurse, with a date of 7/24/12 from 2 PM - 8 PM stated, "Physical therapist here to eval [evaluate] and treat ... Speech therapist here to eval and treat. Notified of pt.</p>	G0143	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. The caregiver for patient #5 has been contacted to discuss the 484.14(g) Coordination of Patient Services. The caregiver and the physician was informed in writing that the agency cannot continue to provide care for patient #5 unless care can be coordinated with the physical therapist and the speech therapist providing care for patient # 5. 2. The physician is being notified in writing that the physical and speech therapist providing care for this patient should have been included in the plan of care for certification period 07/18/12 – 09/15/12. The physician is being notified in writing that agency is attempting to coordinate care with the physical and speech therapist and the need to discharge patient if care coordination cannot be achieved. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. As the result of the findings of this survey, the agency is conducting inservice training for all agency staff 09/18/12-09/25/12. The agenda for this deficiency will include: a). Review of 484.14(g) Coordination of Patient Services and agency policy for compliance with</p>	09/29/2012	

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	<p>[patient] difficulty with chopped steak lunch given on 7/22/12. Made aware of coughing episode. States 'I will follow up with family. Re: food consistency.' "</p> <p>B. On 8/29/12 at 4:10 PM, Employee A indicated the patient's caregiver had requested therapy and hired private therapists to care for the patient.</p> <p>2. The agency policy titled "Care Coordination Policy no. 2 -025.1" with an effective date of 9/21/07 stated, "To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services ... Timely and ongoing communication is the responsibility of each team member, will be appropriate to the needs and abilities of the patient, and will be relevant to the care provided ... Written evidence of care coordination will be recorded during the case conference and repeated in skilled nursing visits in the patient's clinical records ... Care coordination will include, but not be limited to ... E. timely documentation of coordination of care activities F. Appropriate involvement of the patient and caregivers ... 8. Written of evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patient's clinical record."</p>		<p>484.14(g). 2. The agency will inform all patients /caregivers in writing of 484.14(g) Coordination of Patient Services and agency policy and procedures at patient's admission to the agency. 3. Upon learning of other entities or individuals providing care for agency patients, agency will remind & review 484.14(g) Coordination of Patient Services and agency procedure regarding this rule with the patient /caregiver. The agency will notify the patient /caregiver and the physician of plans to discharge patient or make every effort to contact the other entity to coordinate services with that entity if this is a workable solution. If agency is unsuccessful after 5 days, the agency will inform the patient and the ordering physician that agency must discharge the patient. 4. 10% of clinical records will be audit by QA team quarterly to note evidence of care coordination and that this is appropriately integrated into the clinical record. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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G0144	<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 review, interview, and policy review, the agency failed to ensure the coordination of care was maintained with other entities that had provided services in 1 of 3 clinical records reviewed (clinical record 5) of patients receiving additional services from other entities.</p> <p>Findings</p> <p>1. Clinical record #5, SOC 7/24/11, included a plan of care for the certification period of 7/18/12 - 9/15/12 that identified the patient received the services of a speech therapist and physical therapist. No documentation was present to show care coordination with these outside entities. This was evidenced by the following:</p> <p style="padding-left: 40px;">A. A nursing note signed by Employee F, Licensed Practical Nurse, with a date of 7/24/12 from 2 PM - 8 PM stated, "Physical therapist here to eval [evaluate] and treat ... Speech therapist here to eval and treat. Notified of pt. [patient] difficulty with chopped steak</p>			G0144	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The caregiver for patient #5 has been contacted to discuss the 484.14(g) Coordination of Patient Services. The caregiver and the physician was informed in writing that the agency cannot continue to provide care for patient #5 unless care can be coordinated with the physical therapist and the speech therapist providing care for patient #5. This is documented in clinical record #5.</p> <p>2. The physician was notified in writing that the physical and speech therapist providing care for this patient should have been included in the plan of care for certification period 07/18/12 – 09/15/12. The physician was notified in writing that agency is attempting to coordinate care with the physical and speech therapist and the need to discharge patient if care coordination cannot be achieved. This is documented in clinical record #5.</p> <p>TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p>		09/29/2012

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	<p>lunch given on 7/22/12. Made aware of coughing episode. States 'I will follow up with family. Re: food consistency.' "</p> <p>B. On 8/29/12 at 4:10 PM, Employee A indicated the patient's caregiver had requested therapy and hired private therapists to care for the patient.</p> <p>2. The agency policy titled "Care Coordination Policy no. 2 -025.1" with an effective date of 9/21/07 stated, "To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services ... Timely and ongoing communication is the responsibility of each team member, will be appropriate to the needs and abilities of the patient, and will be relevant to the care provided ... Written evidence of care coordination will be recorded during the case conference and repeated in skilled nursing visits in the patient's clinical records ... Care coordination will include, but not be limited to ... E. timely documentation of coordination of care activities F. Appropriate involvement of the patient and caregivers ... 8. Written of evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patient's clinical record."</p>		<p>1. As the result of the findings of this survey, the agency is conducting inservice training for all agency staff 09/18/12- 09/25/12. The agenda for this deficiency will include: a). Review of 484.14(g) Coordination of Patient Services and agency policy for compliance with 484.14(g).</p> <p>2. The agency will inform all patients /caregivers in writing of 484.14(g) Coordination of Patient Services and agency policy and procedures at patient's admission to the agency. This will be documented in the clinical records.</p> <p>3. All of agency employees will be instructed 09/18/12 – 09/25/12 that they have the responsibility of notifying agency of other entities or individuals providing care for agency patients at the time they are aware.</p> <p>4. Conferences will occur between direct care staff and office to report other entities or individuals providing care for agency patients and will be documented in the clinical record. Direct care staff will document these reports in their progress notes. Office staff will document these reports in the clinical records.</p> <p>5. 10% of clinical records will be audit by QA team quarterly to note conferences were completed and information has been appropriately added to the clinical record.</p>		

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			<p>6. Upon learning of other entities or individuals providing care for agency patients, agency will remind & review 484.14(g) Coordination of Patient Services and agency policy and procedure regarding this rule with the patient /caregiver. The agency will notify the patient and the ordering physician for home care of plans to discharge patient or make every effort to contact the other entity to coordinate services with that entity if this is a workable solution. If agency is unsuccessful after 5 days, the agency will inform the patient and the ordering physician that agency must discharge the patient.</p> <p>WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED</p> <p>The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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G0156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record review, policy review, home visit observation, and interview, it was determined the agency failed to ensure blood sugar testing was performed only if ordered on the plan of care for 2 of 3 home visits with home health aides with the potential to affect all the agency's patients who received home health aide services(see G 158), failed to ensure the plan of care was signed by the physician and included all the durable medical equipment and treatments ordered in 6 of 11 records reviewed (see G 159), and failed to ensure the doctor was informed on low blood sugar results for 1 of 2 patients with glucometer test assist noted on home health aide visit notes with the potential to affect all the agency's diabetic patients (see G 164).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision.</p>	G0156	<p>The administrator believes that the agency can return to compliance with G158, G159 and G164 within 30 days of the survey date 08/30/12. After reviewing the events of the survey, exit conference and results of the survey the administrator reviewed the standards outlined in G158, G159 and G164 and the agency's areas of noncompliance. The administrator has informed affected staff of the areas of noncompliance that involves them and the plans of correction. The agency is working to correct all noncompliance with standards that can be corrected at this point. Corrective actions are being taken for the home health aide who performed outside of her scope of practice and to prevent this from occurring in the future for any of agency's staff.</p>	09/29/2012	

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on home visit observation, clinical record review, and interview, the agency failed to ensure blood sugar testing was performed only if ordered on the plan of care for 2 of 3 home visits (#1 and 2) with home health aides with the potential to affect all the agency's patients who received home health aide services.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to test patient #1's blood sugar.</p> <p>a. Clinical record #1, start of care (SOC) 6/29/12, included a plan of care for the certification period of 6/29/12 - 8/27/12 that failed to evidence blood sugar testing was to be performed.</p> <p>b. The aide care plan dated on 6/29/12 and signed by Employee A on 6/29/12 stated, "Assist Glucometer testing."</p> <p>c. On 8/30/12 at 10:50 AM,</p>			G0158	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. There are no orders for any of agency staff to perform blood sugar testing for Patient #1. 'Family caregivers provides', will be listed on the Plan of Care for this procedure. The physician is being notified in writing that this information was not included in the Plan of Care for the certification period of 6/29/12-08/27/12 and 08/28/12-10/26/12. This information will be included in continuing Plans of Care. 2. The agency is instructing home health aides to stop entering the results of blood sugars reported to them in their visit notes. 3. The agency is instructing caregivers to inform the nurse of blood sugar results and not the home health aide. The nurse will report abnormal blood sugars to the physician. 4. The home health aide care plan and visit notes are under revision and glucometer assist is deleted. 5. Employee H is not allowed to perform or assist glucometer testing. Corrective actions are being taken. 6. Corrective actions are being taken for Employee H. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. As the</p>		09/29/2012

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	<p>Employee A indicated the plan of care failed to evidence the HHA should complete the glucometer testing.</p> <p>2. Clinical record #2, SOC 12/19/10, included plans of care for the certification periods of 6/11/12 - 8/9/12 and 8/10/12 - 10/6/12 that failed to evidence blood sugar testing or assist was to be performed by the aide.</p> <p>a. The clinical document titled "Home Health Visit report" dated 8/16/12 and signed by Employee H, HHA, identified a checked box with glucometer test assist and blood sugar of 99.</p> <p>b. The clinical document titled "Home Health Visit report" signed by Employee N, HHA, dated 8/14/12, 8/15/12, and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter (mg/dl).</p> <p>c. The clinical document titled "Home Health Visit report" signed by employee N dated 8/4/12, 8/5/12, 8/6/12, and 8/8/12 listed blood sugars of 79, 98, 94, and 80 mg /dl.</p>		<p>result of the findings of this survey, the agency is conducting inservice training for all agency staff 09/18/12- 09/25/12. The agenda for this deficiency will include: a). Review of 484.18 Acceptance of Patients, POC, Medical Supervision and agency policy for compliance with 484.18. 2. The clinical nurse supervisor will report non-compliance to the Director of Nursing who will take corrective actions. 3. The glucometer assist box in the home health aide care plan and the home health aide visit note has been eliminated in a revised home health aide care plan and revised home health aide visit note. 4. 10% of clinical records will be audit by QA team quarterly to monitor care, orders and the integration of care and orders into the Plan of Care. Non-Compliance will be reported to the Performance Improvement Team and the Director of Nursing. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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G0159	<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 was signed by the physician and included all the durable medical equipment and treatments ordered in 6 of 11 (Clinical records 1, 2, 4, 5, 8 and 9) records reviewed.</p> <p>Findings</p> <p>1. Clinical record #1 start of care (SOC) 6/29/12, included a plan of care for the certification period of 6/29/12 - 8/27/12 that was not signed by the physician in a timely manner. The "Home health certification and plan of care" was signed by the physician on 8/17/12. On 8/30/12 at 10:50 AM, Employee A indicated the physician's signature was not timely.</p>	G0159	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. The ordering physician for clinical record # 2 will be notified in writing that: a)the suction machine and PEG tube dressing ordered were omitted from plan of care certification period 08/10/12 to 10/08/12 and, b) the order for PEG tube dressing was omitted from plan of care certification periods 06/11/12 –08/09/12. 2. The agency is in the process of obtaining signatures from the ordering physicians for Clinical Records #2, #5, and #8. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. As the result of the findings of this survey, the agency is conducting inservice training for agency nurses and medical records staff 09/18/12- 09/25/12. The agenda for this deficiency will include: a) Review of 484.18(a) Plan of Care 2.The administrative assistant managing medical records will monitor all active patient clinical records weekly for compliance</p>	09/29/2012	

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	<p>2. Clinical record #2, SOC 12/19/10, included a plan of care for the certification period of 6/11/12 - 8/9/12 that was not signed by the physician. The clinical record document titled "Home Health Certification and plan of care" for the certification period of 6/11/12 - 8/9/12 was not signed by the physician.</p> <p>On 8/30/12 at 11 AM, Employee A indicated the plan of care did not include a physician signature.</p> <p>3. Clinical record #4, SOC 12/10/10, included a plan of care for the certification period of 8/11/12 - 10/9/12 that failed to evidence orders for wound care and a suction machine. This was evidenced by the following:</p> <p>a. A clinical document with the title of the physician and office dated 3/22/12 and signed by the physician stated, "Mobile Suction Machine."</p> <p>b. A physician's order for a dressing order for a peg tube site was completed on 5/23/12.</p> <p>c. On 8/29/12 at 2:30 PM, Employee A indicated the wound care orders and suctioning machine were not listed on the plan of care.</p>		<p>with 484.18(a) 3. The agency will make every effort to receive timely signatures from the ordering physician for the plan of care. The agency will instruct patients on admission regarding 484.18(a) and agency cannot provide service without timely signatures from their physician. 4. The agency medical director will be informed when the ordering physician has not signed after 14 days to enlist assistance in obtaining the signed Plan of Care. 5. In the event the physician has not signed the Plan of Care in 30 days of the start date, services will be discharged. Both physician and patient will be kept informed throughout the procedure of the anticipated discharge date. 6. The QA team will audit 10% of clinical records quarterly for evidence of timely physician signatures on the plan of care and that the clinical record evidence of all orders for treatments and equipment included in the Plans of Care. Non-compliance will be reported to the Performance Improvement Team and the Director of Nursing. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not</p>				

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	<p>4. Clinical record #5, SOC 7/24/11, included a plan of care for the certification period of 7/18/12 - 9/15/12 that was not signed by the physician.</p> <p>On 8/29/12 at 3:05 PM, Employee A indicted the plan of care was not signed by the physician.</p> <p>5. Clinical record #8, SOC 12/10/11, included a plan of care for the certification period of 12/10/11 - 1/8/12 that was not signed by the physician.</p> <p>On 8/30/12 at 5:10 PM, Employee A indicated the plan of care was not signed by the physician.</p> <p>6. Clinical record #9, SOC 4/29/12, included a plan of care for the certification period 6/28/12 - 8/26/12 evidenced a plan of care that was not signed by the physician until 8/30/12.</p> <p>On 8/30/12 at 2:50 PM, Employee A indicated the plan of care was not signed until 8/30/12.</p> <p>7. The agency policy titled "Client Plan of Care" with the effective date of 9/13/93 stated, "The client plan of care A. is developed by the physician in consultation with the home health care</p>		recur.		

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	staff and interdisciplinary team members B. includes the following ... (2) type of home health care services and equipment required."				

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G0164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the doctor was informed on low blood sugar results for 1 of 2 patients (#1) with glucometer test assist noted on home health aide visit notes with the potential to affect all the agency's diabetic patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 6/29/12, failed to evidence the registered nurse contacted the physician with any low blood sugar results that were recorded at home health aide (HHA) visits</p> <p>a. The clinical document titled "Home Health Visit Report" signed by Employee H, HHA, on August 14 and 15, 2012, identified a glucometer test assists with blood sugars of 64 and 75 consecutively.</p> <p>b. The clinical document titled "Home Health Visit Report" signed by Employee K, HHA on August 13, August 16, and August 17, 2012, identified</p>	G0164	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. 'Family caregivers provides', will be listed on the Plan of Care for glucometer testing for patient #1. The physician is being notified in writing that this information was not included in the Plan of Care for the certification period of 6/29/12-08/27/12 and 08/28/12-10/26/12. This information will be included in continuing Plans of Care.</p> <p>2. The agency is instructing patient /caregivers to inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately.</p> <p>3. The Director of Nursing has instructed home health aides to stop entering the results of blood glucose test reported to them in their visit notes.</p> <p>TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. The agency is conducting inservice training for all agency staff 09/18/12- 09/25/12. The agenda for this deficiency will include: a). Review of 484.18(b) Periodic Review of the Plan of Care and agency policy and procedure for compliance with</p>	09/29/2012			

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	<p>glucometer test assists with blood sugars of 67, 54 and 68 consecutively.</p> <p>c. On 8/30/12 at 10:50 AM, Employee A, director of nursing (DON), indicated the physician was not notified of the above blood sugars logged at the above visits.</p> <p>2. The agency policy titled "Skilled Nursing Services" with a date of 9/13/1993 stated, "The duties of the Home Health Care Registered Nurse include the following ... Informing physicians and home health care staff of changes in client conditions and needs."</p>		<p>484.18(b). 2. The patient /caregivers will inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 3. Home health aides will no longer be instructed / allowed to enter results of blood glucose on their visit reports. 4. 10% of clinical records will be audited quarterly for compliance with 484.18(b). The clinical nurse supervisor will report non-compliance to the Performance Improvement Team and the Director of Nursing who will take corrective actions.</p> <p>WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED</p> <p>The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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G0173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure the registered nurse had obtained orders for blood sugar testing or assist and included all orders in the plan of care for 3 of 11 records reviewed (#1, #2, and #4) with the potential to affect all of the agency's current 24 patients.</p> <p>Findings:</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to test patient #1's blood sugar.</p> <p style="padding-left: 40px;">a. Clinical record #1, start of care (SOC) 6/29/12, included a plan of care for the certification period of 6/29/12 - 8/27/12 that failed to evidence blood sugar testing was to be performed and that the registered nurse had updated the plan of care to include blood sugar testing.</p> <p style="padding-left: 40px;">b. The aide care plan dated on 6/29/12 and signed by Employee A on 6/29/12 stated, "Assist Glucometer testing."</p> <p style="padding-left: 40px;">c. On 8/30/12 at 10:50 AM,</p>	G0173	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. There are no orders for any of agency staff to perform blood sugar testing for Patient #1. Family caregivers provide blood sugar testing for patient #1. 2. 'Family caregivers provides', will be listed on the Plan of Care for this procedure. The physician has been notified in writing that this information was not included in the Plan of Care for the certification period of 6/29/12-08/27/12and 08/28/12 – 10/26/12. This information will be included in continuing Plans of Care. 3. There are no orders for any of agency staff to perform blood sugar testing for Patient #2. Family caregivers provide blood sugar testing for patient #2. 4. 'Family caregivers provides', should be listed on the Plan of Care for this procedure. The physician has been notified in writing that this information was not included in the Plan of Care for the certification period of 06/11/12 - 08/09/12 and 08/10/12 – 10/08/12. This information will be included in continuing Plans of Care. 5. The agency is instructing patient /caregivers to inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The</p>	09/29/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157262		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/30/2012	
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	<p>Employee A indicated the plan of care had not been updated to include the blood sugar testing.</p> <p>2. Clinical record #2, SOC 12/19/10, included plans of care for the certification periods of 6/11/12 - 8/9/12 and 8/10/12 - 10/6/12 that failed to evidence blood sugar testing or assist was to be performed by the aide or that the registered nurse had contacted the physician for orders for blood sugar testing.</p> <p>a. The clinical document titled "Home Health Visit report" dated 8/16/12 and signed by Employee H, HHA, identified a checked box with glucometer test assist and blood sugar of 99.</p> <p>b. The clinical document titled "Home Health Visit report" signed by Employee N, HHA, dated 8/14/12, 8/15/12, and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter (mg/dl).</p> <p>c. The clinical document titled "Home Health Visit report" signed by employee N dated 8/4/12, 8/5/12, 8/6/12, and 8/8/12 listed blood sugars of 79, 98, 94, and 80 mg /dl.</p> <p>d. On 8/30/12 at 11 AM, Employee</p>		<p>Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 6. The Director of Nursing has instructed Home health aides they are no longer allowed to enter results of blood glucose reported to them in their visit notes. 7. The Director of Nursing has reinstructed Home health aides they are not allowed to perform or assist with blood glucose testing. 8. The ordering physician for clinical record# 2 will be notified that: a) the suction machine ordered 03/22/12 and PEG tube dressing ordered 05/23/12 were omitted from plan of care certification period 08/10/12 to 10/08/12 and, b) the order for PEG tube dressing was omitted from plan of care certification periods 06/11/12 – 08/09/12. This information will be included in continuing Plans of Care. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. The agency is conducting inservice training for all agency registered nurses 09/18/12-09/25/12. The agenda for this deficiency will include: a). Review of 484.30(a) Duties of the registered nurse and agency policy and procedure for compliance with 484.30(a). 2. The patient/caregivers will inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in</p>				

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	<p>A indicated that no additional orders for updating the plan of care had been requested.</p> <p>3. Clinical record #4, SOC 12/10/10, included a plan of care for the certification period of 8/11/12 - 10/9/12 that failed to evidence the nurse had updated the plan of care to include wound care and a suction machine.</p> <p>a. A clinical document with the title of the physician and office dated 3/22/12 and signed by the physician stated, "Mobile Suction Machine." This order was not included on the plan of care.</p> <p>b. A physician's order for a dressing order for a peg tube site was completed on 5/23/12. This order was not included on the plan of care.</p> <p>c. On 8/29/12 at 2:30 PM, Employee A indicated the registered nurse had not updated the plan of care with the wound care orders and suctioning machine orders.</p> <p>4. The agency policy titled "Client Plan of Care" with an effective date of 9/13/1993 stated, "The client plan of care is developed by a physician in consultation with the home health care staff and interdisciplinary team members</p>		<p>The Plan of Care. The registered nurse will report abnormal blood glucose levels to the physician appropriately. 3. Home health aides will no longer be instructed / allowed to enter results of blood glucose on their visit reports. 4. 10% of clinical records will be audited quarterly for compliance with 484.30(a). The clinical nurse supervisor will report non-compliance to the Performance Improvement Team and the Director of Nursing who will take corrective actions.</p> <p>WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED</p> <p>The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	... Changes in the plan of care are documented through written plans of modifications, or, if the changes are requested orally, are reduced to writing, signed by a Home Health Care Registered Nurse, and countersigned by the attending physician as soon as possible."			

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G0176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse coordinated care with other entities that had provided services in 1 of 3 clinical records reviewed (clinical record 5) of patients receiving additional services from other entities and informed the doctor of low blood sugar results for 1 of 2 patients (#1) with glucometer test assist noted on home health aide visit notes with the potential to affect all the agency's patients.</p> <p>Findings:</p> <p>Related to coordination of services:</p> <p>1. Clinical record #5, SOC 7/24/11, included a plan of care for the certification period of 7/18/12 - 9/15/12 that identified the patient received the services of a speech therapist and physical therapist. No documentation was present to show care coordination with these outside entities. This was evidenced by</p>			G0176	<p>HOW THE DEFICIENCY WILL BE CORRECTED Related to Care Coordination of services 1. The Director of Nursing will notify the caregiver for patient #5 in writing regarding the regulations for care coordination for home health care agencies and request information to contact the therapist providing services for patient #5. The caregiver will be informed that the agency cannot continue to provide care for patient #5 unless care can be coordinated with the therapist providing care for patient #5. 2. The Director of Nursing will notify the physician for patient #5 in writing that a physical and speech therapist is providing care for this patient and should have been included in the plan of care for certification period 07/18/12 – 09/15/12. The physician will also be notified that the agency is attempting to coordinate care with the physical and speech therapist and the need to discharge patient if care coordination cannot be achieved. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency is conducting inservice training for all agency registered nurses 09/18/12-09/25/12. The agenda</p>		09/29/2012

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	<p>the following:</p> <p>A. A nursing note signed by Employee F, Licensed Practical Nurse, with a date of 7/24/12 from 2 PM - 8 PM stated, "Physical therapist here to eval [evaluate] and treat ... Speech therapist here to eval and treat. Notified of pt. [patient] difficulty with chopped steak lunch given on 7/22/12. Made aware of coughing episode. States 'I will follow up with family. Re: food consistency.' "</p> <p>B. On 8/29/12 at 4:10 PM, Employee A indicated the patient's caregiver had requested therapy and hired private therapists to care for the patient.</p> <p>2. The agency policy titled "Care Coordination Policy no. 2 -025.1" with an effective date of 9/21/07 stated, "To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services ... Timely and ongoing communication is the responsibility of each team member, will be appropriate to the needs and abilities of the patient, and will be relevant to the care provided ... Written evidence of care coordination will be recorded during the case conference and repeated in skilled nursing visits in the patient's clinical records ... Care coordination will include, but not be</p>		<p>for this deficiency will include: a). Review of 484.30(a) Duties of the registered nurse and agency policy and procedure for compliance with 484.30(a). 2. The registered nurse will inform all patients /caregivers regarding the regulations for Coordination of Patient Services and agency policy and procedure regarding this regulation in writing at the time of the patient's admission to the agency. 3. Upon learning of other entities providing care for agency patients, the registered nurse will remind & review with patient /caregiver: 484.30(a) Services and agency policy and procedure regarding 484.30(a) with the patient /caregiver. The agency will make every effort to contact the other entity to coordinate services. If agency is unsuccessful after 5 days. The agency will inform the patient and the ordering physician that the agency must discharge the patient. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Related to Informing the physician: HOW THE DEFICIENCY WILL BE CORRECTED 1. There are no orders for any of agency staff to</p>				

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	<p>limited to ... E. timely documentation of coordination of care activities F. Appropriate involvement of the patient and caregivers ... 8. Written of evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patient's clinical record."</p> <p>Related to Informing the physician:</p> <p>1. Clinical record #1, start of care (SOC) 6/29/12, failed to evidence the registered nurse contacted the physician with any low blood sugar results that were recorded at home health aide (HHA) visits</p> <p>a. The clinical document titled "Home Health Visit Report" signed by Employee H, HHA, on August 14 and 15, 2012, identified a glucometer test assists with blood sugars of 64 and 75 consecutively.</p> <p>b. The clinical document titled "Home Health Visit Report" signed by Employee K, HHA on August 13, August 16, and August 17, 2012, identified glucometer test assists with blood sugars of 67, 54 and 68 consecutively.</p> <p>c. On 8/30/12 at 10:50 AM,</p>		<p>perform blood sugar testing for Patient#1. Family caregivers provide blood sugar testing for patient #1. 2. 'Familycaregivers provides', will be listed on the Plan of Care for this procedure.The physician has been notified in writing that this information was not included in the Plan of Care for the certification period of 6/29/12-08/27/12.This information will be included in continuing Plans of Care. 3. The agency is instructing patient /caregivers to inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in the Plan of Care.The nurse will report abnormal blood glucose levels to the physician appropriately. 4. TheDirector of Nursing has instructed Home health aides they are no longer allowed to enter results of blood glucose obtained by patient / caregivers in their visit notes. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency is conducting inservice training for all agency registered nurses 09/18/12- 09/25/12. The agenda for this deficiency will include: a). Review of 484.30(a) Duties of the registered nurse and agency policy and procedure for compliance with 484.30(a). The agenda will include: a) Review of 484.30(a) Duties of the Registered Nurse and Agency</p>				

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	<p>Employee A, director of nursing (DON), indicated the physician was not notified of the above blood sugars logged at the above visits.</p> <p>2. The agency policy titled "Skilled Nursing Services" with a date of 9/13/1993 stated, "The duties of the Home Health Care Registered Nurse include the following ... Informing physicians and home health care staff of changes in client conditions and needs."</p>		<p>Policy: Skilled Nursing Services, Policies and Procedures for prompt reporting of changes in patient condition. 2. 10% of clinical records will be audited quarterly by the QA Team for changes in condition to be reported to the physician and compliance with 484.30(a). 3. The Administrative Assistant for Medical Records will report non-compliance to the Performance Improvement Team and the Director of Nursing who will take corrective actions. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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G0202	<p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on clinical record review, home visit observation, interview, personnel file review, and policy review, it was determined the agency failed to ensure 3 of 7 home health aide files reviewed identified the aide was competent to perform glucose testing or assist with the potential to affect any of the agency's 24 patients who have glucometer test assist performed at home health aide visits (see G 212, 213, and 227), failed to ensure the registered nurse appropriately assigned glucose testing or assist as part of the aide's tasks for 2 of 2 records reviewed where the aide completed glucose test or assist with the potential to affect any of the agency's 24 patients who have glucometer test assist performed at home health aide visits (see G 224), failed to ensure the aide only performed tasks which the aide was allowed to do by law and in the aide's scope of practice for 1 of 3 aide home visits observed with the potential to affect all the agency's diabetic patients who receive home health aide services (see G 225), and failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days for 1 of 2 records reviewed of patients receiving home health aide and</p>			G0202	<p>The administrator believes that the agency can return to compliance with G212, G213, G224, G225, G227 and G229 within 30 days of the survey date 08/30/12. After reviewing the events of the survey, exit conference and results of the survey the administrator reviewed the standards outlined in G212, G213, G224, G225, G227 and G229 and the agency's areas of noncompliance. The administrator has Informed affected staff of the areas of noncompliance that involves them and the plans of correction. The agency is working to correct all noncompliance with standards that can be corrected at this point.</p> <p>Corrective actions are being taken for the home health aide who performed outside of her scope of practice and to prevent this from occurring in the future for any of agency's staff.</p>		09/29/2012

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	<p>skilled nurse services with the potential to affect all the patients who receive skilled nurse and home health aide services (see G 229).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to ensure safe home health aide care was provided as required by the Condition of Participation 484.36: Home Health Aide services.</p>			

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G0212	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on clinical record review, home visit observation, interview, personnel file review, and policy review, the agency failed to ensure 3 of 7 home health aide files (H, K, and N) reviewed identified the aide was competent to perform glucose testing or assist with the potential to affect any of the agency's 24 patients who have glucometer test assist performed at home health aide visits.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to perform blood sugar testing for Patient #1. Personnel File H, date of hire 8/16/03 and first patient contact 8/25/03, failed to evidence competency training with glucometer test assist.</p> <p>The clinical document titled "Home Health Visit Report" signed by Employee H on August 14 and 15, 2012, listed a glucometer test assists with blood sugars of 64 and 75 consecutively.</p> <p>2. The clinical document titled "Home</p>	G0212	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The agency completes competency testing for tasks within the home health aide scope of practice as outlined in 484.36 Condition of participation: Home health aide services. Agency categorized recording blood glucose as (ii) Observation, reporting and documentation of patient status and the care or service furnished. Agency will categorize this as any other task that the HHA may choose to have the home health aide perform. Agency home health aides have been instructed to cease writing results from reports of glucometer testing in their visit notes. 2. Registered nurses are being inserviced regarding appropriately assigning home health aides to document any additional types of information. The home health aide will be specifically competency tested under any other task that the HHA may choose to have the home health aide perform. 3. Before assigning task on the home health aide care plan, registered nurses will ensure with the Director of Nursing that home health aides are competency</p>	09/29/2012	

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	<p>Health Visit Report" for patient #1 signed by Employee K, HHA, on August 13, August 16, and August 17, 2012, listed glucometer test assists with blood sugars of 67, 54, and 68 consecutively. Personnel File K, HHA, date of hire 5/4/09 and first patient contact 5/8/09, failed to evidence competency training with glucometer test assist.</p> <p>2. The clinical document titled "Home Health Visit report" for patient #2 signed by Employee N, HHA with a dates of 8/14/12, 8/15/12 and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter(mg/dl). The clinical document titled "Home Health Visit report" for patient #2 signed by employee N with the dates of 8/4/12, 8/15/12, 8/6/12 and 8/8/12 indicated blood sugars of 79, 98, 94, and 80 mg /dl. Personnel File N, HHA, date of hire 11/11/11 and first patient contact 11/12/11, failed to evidence competency training with glucometer test assist.</p> <p>3. On 8/28/12 at 10:30 AM, Employee A indicated the agency home health aides listed above had not been competency tested on glucometer assist or glucometer testing and were not to assist or complete glucometer testing.</p> <p>4. The agency policy titled "Home Health</p>		<p>tested to perform the task. 4. Agency competency testing for home health aides does not include glucometer testing or glucometer assisting. 5. The registered nurses have been instructed to delete the glucometer check results from existing home health aide care plans. 6. The registered nurse will review the current care plans with Employee H, Employee K and Employee N to instruct changes. 7. The registered nurse will instruct all home health aides and agency patients /caregivers regarding these changes. 8. Corrective actions are being taken for Employee H. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. The agency is conducting inservice training for all agency registered nurses 09/18/12-09/25/12. The agenda will include: a) 484.36(b)(1) Assignment & Duties of Home Health Aide agency policy and procedure for compliance with 484.36(b)(1). 2. Home health aides will not be instructed / allowed to write any results reported to them on their visit reports unless specifically competency tested for the task. The nurse will obtain information regarding competency testing from the Director of Nursing. 3. Home health aides will not be allowed to perform glucometer testing. 4. Home health aides will not be instructed / allowed to</p>				

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NAME OF PROVIDER OR SUPPLIER HEALTHMASTERS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WILLOWCREEK ROAD SUITE C PORTAGE, IN 46368		
(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	
	Aide Services" with an effective date of 9/13/1993 stated, "The home health care agency provides Home Health Aide services as appropriate ... Home Health aides are carefully trained in ... any other task that the home health care agency may choose to have the home health aide perform."		perform glucometer assist. 5. The Performance Improvement Team will monitor these changes to ensure compliance. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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G0213	<p>484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAI The competency evaluation must address each of the subjects listed in paragraphs (a) (1)(ii) through (xiii) of this section.</p> <p>Based on clinical record review, home visit observation, interview, personnel file review, and policy review, the agency failed to ensure 3 of 7 home health aide files (H, K, and N) reviewed identified the aide was competent to perform glucose testing or assist (any other task the agency may have the home health aide perform) with the potential to affect any of the agency's patients who have glucometer test assist performed at home health aide visits.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to perform blood sugar testing for Patient #1. Personnel File H, date of hire 8/16/03 and first patient contact 8/25/03, failed to evidence competency training with glucometer test assist.</p> <p>The clinical document titled "Home Health Visit Report" signed by Employee H on August 14 and 15, 2012, listed a glucometer test assists with blood sugars of 64 and 75 consecutively.</p>			G0213	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. The agency completes competency testing for tasks within the home health aide scope of practice as outlined in 484.36 Condition of participation: Home health aide services. Agency believed recording blood glucose was (ii) Observation, reporting and documentation of patient status and the care or service furnished. 2. Before assigning home health aides to document any additional types of information reported like the blood glucose results. The home health aide will be specifically competency tested under any other task that the HHA may choose to have the home health aide perform. 3. Agency competency testing for home health aides does not include glucometer testing or glucometer assisting. 4. Employee H was not allowed to perform glucometer testing, only to write the results reported by caregiver for patient #1. 5. Employee H,K, and N were not allowed to assist glucometer testing, only to write the results reported by caregiver for patient #1. 6. The registered nurses have been instructed to delete the glucometer check results from existing home health aide care</p>		09/29/2012

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	<p>2. The clinical document titled "Home Health Visit Report" for patient #1 signed by Employee K, HHA, on August 13, August 16, and August 17, 2012, listed glucometer test assists with blood sugars of 67, 54, and 68 consecutively. Personnel File K, HHA, date of hire 5/4/09 and first patient contact 5/8/09, failed to evidence competency training with glucometer test assist.</p> <p>2. The clinical document titled "Home Health Visit report" for patient #2 signed by Employee N, HHA with a dates of 8/14/12, 8/15/12 and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter(mg/dl). The clinical document titled "Home Health Visit report" for patient #2 signed by employee N with the dates of 8/4/12, 8/15/12, 8/6/12 and 8/8/12 indicated blood sugars of 79, 98, 94, and 80 mg /dl. Personnel File N, HHA, date of hire 11/11/11 and first patient contact 11/12/11, failed to evidence competency training with glucometer test assist.</p> <p>3. On 8/28/12 at 10:30 AM, Employee A indicated the agency home health aides listed above had not been competency tested on glucometer assist or glucometer testing and were not to assist or complete glucometer testing.</p>		<p>plans. 7. Home health aides have been instructed to stop addressing the glucometer element of the home health aide care plan and visit notes.8. The home health aide care plan and visit report are under revision and inclusion of glucometer will be eliminated. 9. The registered nurse will instruct home health aides and agency patients /caregivers regarding these changes. 10. Corrective actions are being taken for Employeee H.TO ENSURE THIS DEFICIENCY WILL NOT RECUR1. The agency will complete competency testing for tasks within the home health aide scope of practice as outlined in 484.36 Condition of participation: Home health aide services. 2. Before assigning home health aides to document any additional tasks, the home health aide will be specifically competency tested under any other task that the HHA may choose to have the home health aide perform. 3. The element glucometer assist has been eliminated from the Home Health Aide Care Plan and the Home Health Aide Visit Report. 4. The agency is conducting inservice training for registered nurses and home health aides. The agenda includes: a) Review of 484.36(b) (1) Competency Evaluation and Inservice Training and Agency Policy and Procedure for compliance with 484.36(b)1), and</p>				

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	4. The agency policy titled "Home Health Aide Services" with an effective date of 9/13/1993 stated, "The home health care agency provides Home Health Aide services as appropriate ... Home Health aides are carefully trained in ... any other task that the home health care agency may choose to have the home health aide perform."		Home Health Aide Duties and Job Description. 5. An additional clinical nurse supervisor is being hired to concentrate on the supervision of home health aides focusing on scope of practice. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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G0224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record review, home visit observation, interview, personnel file review, and policy review, the agency failed to ensure the registered nurse appropriately assigned glucose testing or assist as part of the aide's tasks for 2 of 2 records reviewed where the aide completed glucose test or assist (#1 and 2) with the potential to affect any of the agency's 24 patients who have glucometer test assist performed at home health aide visits.</p> <p>Findings</p> <p>1. Clinical record #1, start of care 6/29/12 with a certification period of 6/29/12 - 8/27/12 contained a Home Health Aide Care plan dated 6/29/12. Under the section titled Tasks, the RN assigned assist glucometer testing to be done during each visit by home health aides.</p> <p>a. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA),</p>	G0224	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The agency completes competency testing for tasks within the home health aide scope of practice as outlined in 484.36 Condition of participation: Home health aide services. Agency categorized recording blood glucose as (ii) Observation, reporting and documentation of patient status and the care or service furnished. Agency will categorized this as any other task that the HHA may choose to have the home health aide perform. Agency home health aides have been instructed to cease writing results from reports of glucometer testing in their visit notes. 2. Registered nurses are being inserviced regarding appropriately assigning home health aides to document any additional types of information. The home health aide will be specifically competency tested under any other task that the HHA may choose to have the home health aide perform before additional tasks can be assigned / performed which must be in home health aide their scope of practice. 3. Before assigning</p>	09/29/2012			

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	<p>was observed to perform blood sugar testing for Patient #1. Personnel File H, date of hire 8/16/03 and first patient contact 8/25/03, failed to evidence competency training with glucometer test assist.</p> <p>The clinical document titled "Home Health Visit Report" signed by Employee H on August 14 and 15, 2012, listed a glucometer test assists with blood sugars of 64 and 75 consecutively.</p> <p>b. The clinical document titled "Home Health Visit Report" for patient #1 signed by Employee K, HHA, on August 13, August 16, and August 17, 2012, listed glucometer test assists with blood sugars of 67, 54, and 68 consecutively. Personnel File K, HHA, date of hire 5/4/09 and first patient contact 5/8/09, failed to evidence competency training with glucometer test assist.</p> <p>2. The aide care plan dated 2/11/12 by Employee A included glucometer test assist to be completed by the HHA at every visit. Clinical record #2 failed to evidence an order for glucometer test assist.</p> <p>a. The clinical document titled "Home Health Visit report" for patient #2</p>		<p>task on the home health aide care plan, registered nurses will ensure with the Director of Nursing that home health aides are competency tested to perform the task. 4. Agency competency testing for home health aides does not include glucometer testing or glucometer assisting. 5. The registered nurses have been instructed to delete the glucometer check results from existing home health aide care plans. 6. The registered nurse will review the current care plans with Employee H, Employee K and Employee N to instruct changes. 7. The registered nurse will instruct all home health aides and agency patients / caregivers regarding these changes. 8. Corrective actions are being taken for Employee H.TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. The agency is conducting inservice training for all agency registered nurses 09/18/12-09/25/12. The agenda will include: a) 484.36(c)(1) Assignment & Duties of Home Health Aide agency policy and procedure for compliance with 484.36(c)(1). 2. Home health aides will not be allowed to write any results reported to them on their visit reports unless specifically competency tested for the task. The nurse will obtain information regarding competency testing from the Director of Nursing. 3. Home</p>				

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	<p>signed by Employee N, HHA with a dates of 8/14/12, 8/15/12 and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter(mg/dl). The clinical document titled "Home Health Visit report" for patient #2 signed by employee N with the dates of 8/4/12, 8/15/12, 8/6/12 and 8/8/12 indicated blood sugars of 79, 98, 94, and 80 mg /dl. Personnel File N, HHA, date of hire 11/11/11 and first patient contact 11/12/11, failed to evidence competency training with glucometer test assist.</p> <p>3. On 8/28/12 at 10:30 AM, Employee A indicated the agency home health aides listed above had not been competency tested on glucometer assist or glucometer testing and were not to assist or complete glucometer testing.</p> <p>4. The agency policy titled "Home Health Aide Services" with an effective date of 9/13/1993 stated, "The home health care agency provides Home Health Aide services as appropriate ... Home Health aides are carefully trained in ... any other task that the home health care agency may choose to have the home health aide perform ... The Home Health Care Registered Nurse gives written instructions for client care to the Home Health aide as appropriate."</p>		<p>health aides will not be allowed to perform glucometer testing. 4. Home health aides will not be instructed / allowed to perform glucometer assist. 5. The Performance Improvement Team will monitor these changes to ensure compliance. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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G0225	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on home visit observation and interview, the agency failed to ensure the aide (Employee H) only performed tasks which the aide was allowed to do by law and in the aide's scope of practice for 1 of 3 aide home visits (#1) observed with the potential to affect all the agency's diabetic patients who receive home health aide services.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to perform glucometer blood sugar testing on patient #1. Employee A, the administrator / director of nursing, was present while Employee H completed this task.</p> <p>2. On 8/28/12 at 10:30 AM, Employee A indicated performing a blood sugar check with a glucometer, test strips, and a lancet was out of the aide's scope of practice.</p>			G0225	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. As the result of the findings of this survey, the agency is conducting inservice training for all agency staff 09/18/12 – 09/25/12. The agenda includes: a) Review of 484.36(c)(2) Competency Evaluation and inservice training and Agency Policy and Procedure for compliance with 484.36(c)(2), Home Health Aide Duties and Job Description.</p> <p>2. Home Health Aides were reminded they are not allowed to perform blood sugar testing.</p> <p>3. Corrective actions are being taken for Employee H.</p> <p>TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. The agency will continue its practice of not allowing home health aides to perform glucometer testing. When the administrator / Director of Nursing was aware of this action occurring it was already ending. In the future, if such action occurs in sight of a nurse. The nurse will intervene to disrupt the procedure.</p> <p>2. Corrective actions are being taken for Employee H.</p> <p>3. The agency will continue to prohibit home health aides from</p>		09/29/2012

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			<p>performing glucometer testing and glucometer test assisting.</p> <p>4. Registered nurses supervising home health aides will monitor the actions of home health aides focusing on scope of practice to ensure that this does not recur.</p> <p>5. The Performance Improvement Team will monitor these changes to ensure compliance.</p> <p>WHO IS RESPONSIBLE TO ENSURE THAT THEDEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED</p> <p>The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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G0227	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Any home health aide services offered by an HHA must be provided by a qualified home health aide.</p> <p>Based on clinical record review, home visit observation, interview, personnel file review, and policy review, the agency failed to ensure 3 of 7 home health aide files (H, K, and N) reviewed identified the aide was competent to perform glucose testing or assist with the potential to affect any of the agency's 24 patients who have glucometer test assist performed at home health aide visits.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to perform blood sugar testing for Patient #1. Personnel File H, date of hire 8/16/03 and first patient contact 8/25/03, failed to evidence competency training with glucometer test assist.</p> <p>The clinical document titled "Home Health Visit Report" signed by Employee H on August 14 and 15, 2012, listed a glucometer test assists with blood sugars of 64 and 75 consecutively.</p> <p>2. The clinical document titled "Home Health Visit Report" for patient #1 signed</p>	G0227	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The agency completes competency testing for tasks within the home health aide scope of practice as outlined in 484.36 Condition of participation: Home health aide services. Agency believed recording blood glucose was (ii) Observation, reporting and documentation of patient status and the care or service furnished. Agency will categorize this as any other task that the HHA may choose to have the home health aide perform.</p> <p>2. Registered nurses are being inserviced regarding appropriately assigning home health aides to document any additional types of information. The home health aide will be specifically competency tested under any other task that the HHA may choose to have the home health aide perform before additional task can be assigned / performed which must bein home health aide scope of practice.</p> <p>3. Before assigning task on the home health aide care plan, registered nurses will ensure with the Director of Nursing that home health aides are competency tested to perform the task.</p> <p>4. Agency competency testing for</p>	09/29/2012	

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	<p>by Employee K, HHA, on August 13, August 16, and August 17, 2012, listed glucometer test assists with blood sugars of 67, 54, and 68 consecutively. Personnel File K, HHA, date of hire 5/4/09 and first patient contact 5/8/09, failed to evidence competency training with glucometer test assist.</p> <p>2. The clinical document titled "Home Health Visit report" for patient #2 signed by Employee N, HHA with a dates of 8/14/12, 8/15/12 and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter(mg/dl). The clinical document titled "Home Health Visit report" for patient #2 signed by employee N with the dates of 8/4/12, 8/15/12, 8/6/12 and 8/8/12 indicated blood sugars of 79, 98, 94, and 80 mg /dl. Personnel File N, HHA, date of hire 11/11/11 and first patient contact 11/12/11, failed to evidence competency training with glucometer test assist.</p> <p>3. On 8/28/12 at 10:30 AM, Employee A indicated the agency home health aides listed above had not been competency tested on glucometer assist or glucometer testing and were not to assist or complete glucometer testing.</p> <p>4. The agency policy titled "Home Health Aide Services" with an effective date of</p>		<p>home health aides does not include glucometer testing or glucometer assisting. 5. The registered nurses have been instructed to delete the glucometer check results from existing home health aide care plans. 6. The registered nurse will review the current care plans with Employee H, Employee K and Employee N to instruct changes. 7. The registered nurse will instruct all home health aides and agency patients / caregivers regarding these changes. 8. Corrective actions will be taken for Employee H. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency is conducting inservice training for all agency registered nurses 09/18/12- 09/25/12. The agenda will include: a) 484.36(c) (2) Assignment & Duties of Home Health Aide agency policy and procedure for compliance with 484.36(c)(2). 2. Home health aides will not be allowed to write any results reported to them on their visit reports unless specifically competency tested for the task. The nurse will obtain information regarding competency testing from the Director of Nursing. 3. Home health aides will not be allowed to perform glucometer testing. 4. Home health aides will not be instructed / allowed to perform glucometer assist. 5. The Performance Improvement Team will monitor these changes to</p>				

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	9/13/1993 stated, "The home health care agency provides Home Health Aide services as appropriate ... Home Health aides are carefully trained in ... any other task that the home health care agency may choose to have the home health aide perform."		ensure compliance. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

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G0229	<p>484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days for 1 of 2 records reviewed (#11) of patients receiving home health aide and skilled nurse services with the potential to affect all the patients who receive skilled nurse and home health aide services.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Clinical record #11, start of care 5/29/12, included a plan of care for the certification period 5/29/12 - 7/27/12 with orders for skilled and home health aide services. The record failed to evidence any documentation of supervisory visits for the home health aide services except on 7/10/12. 2. On 8/30/12 at 5:10 PM Employee A indicated there was no additional documentation to evidence home health aide supervisory visits. 3. The agency policy titled "Home Health 			G0229	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. As the result of the findings of this survey, the agency is conducting inservice training for agency registered nurse staff and scheduling department staff. The agenda for this deficiency will include: a) Review of 484.36(d)(2) Supervision and Agency Policy and Procedure for compliance with 484.36(d)2. 2. Additional procedures for scheduling and monitoring of home health supervisory visits to ensure compliance will be added. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. All Home Health Aide Supervisory visits will be scheduled by the scheduling department in compliance with 484.36(d)2. The registered nurses will receive a copy of the supervisory visit schedule for home health aides. The scheduling department will monitor the completion of the supervisory visits, and report non-compliance to the Director of Nursing. 2. 10% of clinical records will be audited by QA team quarterly to note compliance with 484.36(d)2. The QA team will report this information to the Director of Nursing and the</p>		09/29/2012

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	Aide supervisory visits" with an effective date of 9/13/93 stated, "A Home Health Care Registered Nurse makes a Home Health Aide supervisory visit to the client residence at least every two weeks, either when the Home Health Aide is present to observe and assist, or when the Home Health Aide is absent ... "		Performance Improvement Team. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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G0236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure 1 of 4 closed records reviewed (#8) contained signed and dated progress notes with the potential to affect all the patient records of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> On 8/30/12 at 10:10 AM, clinical record #8, start of care 12/10/11 and discharge date of 1/21/12, was requested. On 8/30/12 at 2:35 PM, Clinical record #8 was requested for the third time. This record presented failed to include signed and dated clinical progress notes. On 8/30/12 at 2:35 PM, Employee A, the administrator and director of nursing, indicated the above record was incomplete. Employee A stated, "I looked 	G0236	<p>HOW THE DEFICIENCY WILL BE CORRECTED The progress notes for Clinical record #8 were located in a thinned file and both files were merged into one. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. As the result of the findings of this survey, the agency is conducting inservice training for agency medical records staff. The agenda for this deficiency will include: a) Review of 484.48 Clinical Records and Agency Policy and Procedure for compliance with 484.48 2. The Director of Nursing will establish a section in the clinical record to identify thinned files (content and location) to improve timely access of the entire file. The Director of Nursing will re-instruct medical records staff regarding parts of the clinical record which can be thinned due to overflow and parts which should continuously remain in the main file. WHO IS RESPONSIBLE TO ENSURE</p>	09/29/2012	

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	<p>in the record room and was not able to find the entire record."</p> <p>4. The agency policy titled "Client Clinical Record" with an effective date of 9/13/1993 stated, "Client clinical records are maintained in accordance with professional standards. Client clinical records contain ... signed and dated client clinical notes written on the day service is rendered, ... g. signed and dated client progress notes."</p>		<p>THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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G0239	<p>484.48(b) PROTECTION OF RECORDS Clinical record information is safeguarded against loss or unauthorized use.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the clinical record was safeguarded against loss for 1 of 4 closed records reviewed (#8) with the potential to affect all the patient records of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> On 8/30/12 at 10:10 AM, clinical record #8, start of care 12/10/11 and discharge date of 1/21/12, was requested. On 8/30/12 at 2:35 PM, Clinical record #8 was requested for the third time. This record presented failed to include signed and dated clinical progress notes. On 8/30/12 at 2:35 PM, Employee A, the administrator and director of nursing, indicated the above record was incomplete. Employee A stated, "I looked in the record room and was not able to find the entire record." The agency policy titled "Client Clinical Record" with an effective date of 9/13/1993 stated, "Client clinical records 	G0239	<p>HOW THE DEFICIENCY WILL BE CORRECTED The progress notes for Clinical record #8 were located in a thinned file and both files were merged into one. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. As the result of the findings of this survey, the agency is conducting inservice training for agency medical records staff. The agenda for this deficiency includes: a) Review of 484.48(b) Clinical Records and Agency Policy and Procedure for compliance with 484.48(b) 2. The Director of Nursing will establish a section in the clinical record to identify thinned files (content and location) to improve timely access of the entire file. The Director of Nursing will re-instruct medical records staff regarding parts of the clinical record which can be thinned due to overflow and parts which should continuously remain in the main file. 3. 10% of clinical records will be audit by QA team quarterly to note evidence of appropriate storage of clinical records to remain in compliance with 484.48(b). WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of</p>	09/29/2012	

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	are maintained in accordance with professional standards. ... Client clinical records are retained and protected."		Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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G0246	<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 review and interview, the agency failed to have a quality assessment and performance improvement program for 1 of 1 agency with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. At 8/30/12 at 3:30 PM, the administrator indicated there was no completed quality assurance and performance improvement program for 2011 or 2012.</p> <p>2. The agency policy titled "Scope of Quality Management Program" dated 9/13/93 stated, "The home health care agency develops and implements a quality management program."</p>			G0246	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. The agency hired a consultant to assist with restructuring and the monitoring of the quality assurance and performance improvement programs to comply with 484.52. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency will complete the restructuring of the quality assurance and performance improvement programs to conform to the requirements of 484.52. 2. The consultant will offer continuing guidance for the quality assurance and performance improvement programs to assist compliance with 484.52. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		09/29/2012

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N0456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on agency policy review and interview, the agency failed to have a quality assessment and performance improvement program for 1 of 1 agency with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. At 8/30/12 at 3:30 PM, the administrator indicated there was no completed quality assurance and performance improvement program for 2011 or 2012.</p> <p>2. The agency policy titled "Scope of Quality Management Program" dated 9/13/93 stated, "The home health care agency develops and implements a quality management program."</p>	N0456	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. The agency hired a consultant to assist with restructuring and the monitoring of the quality assurance and performance improvement programs to assist agency into compliance with 410 IAC 17-12-1(e). TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency will complete the restructuring of the quality assurance and performance improvement programs to conform to the requirements of 410 IAC 17-12-1(e). 2. The consultant will offer continuing guidance for the quality assurance and performance improvement programs to assist compliance with 410 IAC 17-12-1(e). WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected</p>	09/29/2012			

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			and will not recur.	

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N0470	<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 home visit observation, policy review, and interview, the agency failed to ensure employees followed infection control policies at 1 of 3 home visits with home health aides (Employee H) with the potential to affect all of the patients of the agency receiving home health aide services.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), set up a glucometer with a test strip and also placed a lancet on a paper towel and then proceeded to check the blood sugar by uncapping the lancet and pricking one finger of Patient #1. Employee H placed a blood droplet onto the strip. The glucometer reading for the blood sugar was 73. Then Employee H pulled the used glucometer strip out of the glucometer machine and placed it onto the paper towel with the used lancet and picked these up and threw the paper towel and contents into the household trash.</p>	N0470	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The agency is conducting inservice training for all agency staff 09/18/12- 09/25/12. The agenda includes: a) Review of 410 IAC 17-12-1(m) and Agency Policy and Procedure for compliance with 410 IAC 17-12-1(m); Infection Control, and c) home health aide care plan and visit report revisions. 2. On 08/28/12 the Director of Nursing contacted the Registered Nurses supervising Employee H, to question their knowledge of Employee H or any other Home Health Aide performing glucometer testing on agency patients and listed their response. The nurses denied any knowledge of this task being performed by any of agencies Home Health Aides. 3. On 08/28/12 The Director of Nursing instructed agency administrative office staff to immediately begin contacting all of its patients who have diabetes and receive home health care services or their caregivers to review procedures regarding any glucometer testing performed in their home and to ask the patient / caregiver to</p>	09/29/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157262	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/30/2012
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	<p>Employee H had gloves on during this procedure. Employee A, the administrator / director of nursing, was present while Employee H completed this task.</p> <p>2. On 8/28/12 at 10:30 AM, Employee A indicated the HHA was at risk of a blood borne pathogen due to the completion of the blood sugar check noted above.</p> <p>3. The agency policy titled "Infection Control / Maintenance of Environment / Equipment" with an effective date of 9/13/93 stated, "Client infection control procedures include, but are not limited to, the following: appropriate handling and disposal of waste products."</p>		<p>disclose who performs this procedure in their home and list their response. The response for each was the patient or the caregiver and denied any home health aide involvement in their glucometer testing procedure. 4. On 08/28/12 The Director of Nursing instructed agency staff to immediately begin contacting all of its Home Health Aide staff to review their duties per their scope of practice as it applied to glucometer testing of patient's assigned to them and listed their response. The response was they are not performing glucometer testing on any patients and understand that to be a task they are not allowed to do. 5. On 08/28/12, the Administrator / Director of Nursing conference with Employee H regarding unauthorized performing of glucometer testing. Employee H was reinstructed that home health aides are not allowed to perform or assist glucometer testing only write results reported to them. Employee H was instructed that the used lancet in the garbage is an infection control issue, was instructed not to add anything else into the container, to store the garbage container in a corner of the room for agency to dispose of the biohazard. The caregiver was intructed to leave the container in the corner. The administrator retrieved the lancet and disposed of lancet in a biohazard sharps container. 6.</p>		

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			<p>Corrective actions are being taken for Employee H. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. As a visual reminder for home health aide duties. A document will be added to the Home clinical record titled 'Task that the Home Health Aides can perform for patients and tasks home health aides cannot perform for patients'. The registered nurse will review this document with patients and home health aides during supervisory visits and document this in the Home Health Aide Supervisory Report.</p> <p>2. An additional Clinical Nurse Supervisor is in the hiring process to provide increased education and supervision of home health aide care with focus on scope of practice.</p> <p>3. Glucometer testing is within the scope of practice for nurses. Training to perform blood testing includes specific infection control techniques such as disposal of used lancets at the point of use in an approved sharps container. Infection control education and training for nurses include managing biohazards (sharps and blood). The agency's nurses are the only agency staff authorized to perform blood glucose testing. When the procedure is the agency's responsibility it is a nursing function for which either a registered nurse or a licensed practical nurse is assigned this duty which will be identified as a</p>	

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			<p>technical procedure for the nurse on the Plan of Care. 4. 10% of clinical records will be audited quarterly by the QA Team for documentation of any task not allowed by the home health aide and the Infection Control Log concurrently for evidence of associated infections. Non-compliance will be reported to the Director of Nursing. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0472	<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. Based on agency policy review and interview, the agency failed to have a quality assessment and performance improvement program for 1 of 1 agency with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. At 8/30/12 at 3:30 PM, the administrator indicated there was no completed quality assurance and performance improvement program for 2011 or 2012.</p> <p>2. The agency policy titled "Scope of Quality Management Program" dated 9/13/93 stated, "The home health care agency develops and implements a quality management program."</p>	N0472	<p>HOW THE DEFICIENCY WILL BE CORRECTED1. The agency hired a consultant to assist with restructuring and the monitoring of the quality assurance and performance improvement programs to assist with bringing the agency into compliance with 410 IAC 17-12-2 (a). TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency will complete the restructuring of the quality assurance and performance improvement programs to conform to the requirements of 410 IAC 17-12-2(a). 2. The consultant will offer continuing guidance for the quality assurance and performance improvement programs to assist compliance with 410 IAC 17-12-2(a). WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED</p>	09/29/2012			

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			<p>AND COMPLIANCE MAINTAINED</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0486	<p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the coordination of care was maintained with other entities that had provided services in 1 of 3 clinical records reviewed (clinical record 5) of patients receiving additional services from other entities.</p> <p>Findings</p> <p>1. Clinical record #5, SOC 7/24/11, included a plan of care for the certification period of 7/18/12 - 9/15/12 that identified the patient received the services of a speech therapist and physical therapist. No documentation was present to show care coordination with these outside entities. This was evidenced by the following:</p> <p style="padding-left: 40px;">A. A nursing note signed by Employee F, Licensed Practical Nurse, with a date of 7/24/12 from 2 PM - 8 PM stated, "Physical therapist here to eval [evaluate] and treat ... Speech therapist here to eval and treat. Notified of pt. [patient] difficulty with chopped steak</p>			N0486	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The caregiver for patient #5 has been contacted to discuss the 410 IAC 17-12-2(h). The caregiver and the physician was informed in writing that the agency cannot continue to provide care for patient #5 unless care can be coordinated with the physical therapist and the speech therapist providing care for patient # 5. 2. The physician is being notified in writing that the physical and speech therapist providing care for this patient should have been included in the plan of care for certification period 07/18/12 – 09/15/12. The physician is being notified in writing that agency is attempting to coordinate care with the physical and speech therapist and the need to discharge patient if care coordination cannot be achieved. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. As the result of the findings of this survey, the agency is conducting inservice training for all agency staff 09/18/12-09/25/12. The agenda for this deficiency will include: a). Review of 410 IAC 17-12-2(h) and agency policy for compliance with 410 IAC 17-12-2(h). 2. The agency will inform all patients</p>		09/29/2012

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	<p>lunch given on 7/22/12. Made aware of coughing episode. States 'I will follow up with family. Re: food consistency.' "</p> <p>B. On 8/29/12 at 4:10 PM, Employee A indicated the patient's caregiver had requested therapy and hired private therapists to care for the patient.</p> <p>2. The agency policy titled "Care Coordination Policy no. 2 -025.1" with an effective date of 9/21/07 stated, "To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services ... Timely and ongoing communication is the responsibility of each team member, will be appropriate to the needs and abilities of the patient, and will be relevant to the care provided ... Written evidence of care coordination will be recorded during the case conference and repeated in skilled nursing visits in the patient's clinical records ... Care coordination will include, but not be limited to ... E. timely documentation of coordination of care activities F. Appropriate involvement of the patient and caregivers ... 8. Written of evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patient's clinical record."</p>		<p>/caregivers in writing of 410 IAC 17-12-2(h). and agency policy and procedures at patient's admission to the agency. 3. Upon learning of other entities or individuals providing care for agency patients, agency will remind & review 410 IAC 17-12-2(h) and agency procedure regarding this rule with the patient /caregiver. The agency will notify the patient /caregiver and the physician of plans to discharge patient or make every effort to contact the other entity to coordinate services with that entity if this is a workable solution. If agency is unsuccessful after 5 days, the agency will inform the patient and the ordering physician that agency must discharge the patient. 4. 10% of clinical records will be audit by QA team quarterly to note evidence of care coordination and that this is appropriately integrated into the clinical record. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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N0514	<p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on policy review, document review, and interview, the agency failed to ensure complaints and the resolution of complaints were documented for 1 of 1 agency with the potential to affect all the agency's patients and family members who complain.</p> <p>Findings</p> <p>1. At an interview with a caregiver for patient #5 on 8/28/12 at 3:15 PM, the caregiver indicated a complaint had been made about a month ago and it had been resolved satisfactorily.</p> <p>2. On 8/29/12 at 2:20 PM, the complaint log failed to evidence the complaint made by the caregiver of patient #5.</p>	N0514	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The complaint for Patient #5 dated 07/09/12 has been completed and is filed in the Complaint Book. The person (caregiver for patient #5) was notified in writing of the results of the investigation and the resolution of the complaint. The complaint was resolved to the caregiver's satisfaction. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. As the result of the findings of this survey, the agency is conducting inservice training for all agency staff 09/18/12 -09/25/12. The agenda includes: Review of 410 IAC 17-12-3(c) and Agency Policy and Procedure for compliance with 410IAC 17-12-3(c). 2. A copy of agency's procedure for managing complaints will be issued to patients on admission and</p>	09/29/2012			

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	<p>3. On 8/30/12 at 10:10 AM, the complaint documentation was requested again. The administrator indicated the complaint documentation was not complete.</p> <p>4. On 8/30/12 at 5:15 PM, the alternate administrator provided the complaint documentation completed on 7/9/12 and reviewed on 7/15/12 with the investigation and resolution and indicated the complaint had been resolved with patient satisfaction. The administrator indicated the complaint log had not been updated because the complaint documentation had been incomplete until this time.</p> <p>5. The agency policy titled "Complaint / Grievance Process" with an effective date of 9/21/07 stated, "The organizational personnel receiving the complaint will discuss verbally and in writing the grievance with the clinical supervisor within 5 days of the alleged grievance. The clinical supervisor will investigate the grievance within 5 days after receipt of such grievance and will make every effort to resolve the grievance to the patient's satisfaction. Response to the patient regarding the complaint will occur within 10 days of receipt ... All complaints will be logged, tracked,</p>		<p>reviewed with patient at any time a complaint is made. The agency will at the time of receiving a complaint initiate the agency complaint process per agency policy and procedures to include documentation of the: a) receipt of complaints, b) investigation of complaints, c) resolution of complaints, and a copy of the written response to the patient or other person making the complaint to inform of the results of the investigation and the resolution of the complaint, d) a copy of the written response will also be provided to the Director of Nursing. This process will be completed within 10 days of receiving the complaint. 3. A Performance Improvement Team will monitor the existence of complaints and progress to completion of the complaint procedure to ensure the procedure is completed and completed within the time guidelines of the complaint process in compliance with 410 IAC 17-12-3(c) and Agency Policy and Procedure for compliance with 410 IAC 17-12-3(c). 4. The Director of Nursing or designee will maintain a complaint log for tracking these procedures. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective</p>		

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	trended and filed in the performance improvement office."		actions to ensure that this deficiency is corrected and compliance will be maintained.		

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on home visit observation, clinical record review, and interview, the agency failed to ensure blood sugar testing was performed only if ordered on the plan of care for 2 of 3 home visits (#1 and 2) with home health aides with the potential to affect all the agency's patients who received home health aide services.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to test patient #1's blood sugar.</p> <p>a. Clinical record #1, start of care (SOC) 6/29/12, included a plan of care for the certification period of 6/29/12 - 8/27/12 that failed to evidence blood sugar testing was to be performed.</p> <p>b. The aide care plan dated on 6/29/12 and signed by Employee A on 6/29/12 stated, "Assist Glucometer testing."</p> <p>c. On 8/30/12 at 10:50 AM, Employee A indicated the plan of care</p>	N0522	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. There are no orders for any of agency staff to perform blood sugar testing for Patient #1. 'Family caregivers provides', will be listed on the Plan of Care for this procedure. The physician is being notified in writing that this information was not included in the Plan of Care for the certification period of 6/29/12-08/27/12 and 08/28/12-10/26/12. This information will be included in continuing Plans of Care. 2. The agency is instructing home health aides to stop entering the results of blood sugars reported to them in their visit notes. 3. The agency is instructing caregivers to inform the nurse of blood sugar results and not the home health aide. The nurse will report abnormal blood sugars to the physician. 4. The home health aide care plan and visit notes are under revision and glucometer assist is deleted. 5. Patient H is not instructed / allowed to perform or assist glucometer testing. 6. Corrective actions are being taken for Employee H. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. As the result of the findings of this</p>	09/29/2012			

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	<p>failed to evidence the HHA should complete the glucometer testing.</p> <p>2. Clinical record #2, SOC 12/19/10, included plans of care for the certification periods of 6/11/12 - 8/9/12 and 8/10/12 - 10/6/12 that failed to evidence blood sugar testing or assist was to be performed by the aide.</p> <p>a. The clinical document titled "Home Health Visit report" dated 8/16/12 and signed by Employee H, HHA, identified a checked box with glucometer test assist and blood sugar of 99.</p> <p>b. The clinical document titled "Home Health Visit report" signed by Employee N, HHA, dated 8/14/12, 8/15/12, and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter (mg/dl).</p> <p>c. The clinical document titled "Home Health Visit report" signed by employee N dated 8/4/12, 8/5/12, 8/6/12, and 8/8/12 listed blood sugars of 79, 98, 94, and 80 mg /dl.</p>		<p>survey, the agency is conducting inservice training for all agency staff 09/18/12- 09/25/12. The agenda for this deficiency will include: a). 410 IAC 17-13-1(a) for compliance with 410 IAC 17-13-1(a). 2. The clinical nurse supervisor will report non-compliance to the Director of Nursing who will take corrective actions. 3. The glucometer assist box in the home health aide care plan and the home health aide visit note has been eliminated in a revised home health aide care plan and revised home health aide visit note. 4. 10% of clinical records will be audit by QA team quarterly to monitor care, orders and the integration of care and orders into the Plan of Care. Non-Compliance will be reported to the Performance Improvement Team and the Director of Nursing. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the plan of care was signed by the physician and included all the durable medical equipment and treatments ordered in 6 of 11 (Clinical records 1, 2, 4, 5, 8 and 9) records reviewed.</p> <p>Findings</p>	N0524	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. The ordering physician for clinical record # 2 will be notified in writing that: a) the suction machine and PEG tube dressing ordered were omitted from plan of care certification period 08/10/12 to 10/08/12 and, b) the order for PEG tube dressing was omitted from plan of care certification periods 06/11/12 – 08/09/12. 2. The agency is in the process of obtaining signatures from the ordering physicians for Clinical</p>	09/29/2012			

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	<p>1. Clinical record #1 start of care (SOC) 6/29/12, included a plan of care for the certification period of 6/29/12 - 8/27/12 that was not signed by the physician in a timely manner. The "Home health certification and plan of care" was signed by the physician on 8/17/12.</p> <p>On 8/30/12 at 10:50 AM, Employee A indicated the physician's signature was not timely.</p> <p>2. Clinical record #2, SOC 12/19/10, included a plan of care for the certification period of 6/11/12 - 8/9/12 that was not signed by the physician. The clinical record document titled "Home Health Certification and plan of care" for the certification period of 6/11/12 - 8/9/12 was not signed by the physician.</p> <p>On 8/30/12 at 11 AM, Employee A indicated the plan of care did not include a physician signature.</p> <p>3. Clinical record #4, SOC 12/10/10, included a plan of care for the certification period of 8/11/12 - 10/9/12 that failed to evidence orders for wound care and a suction machine. This was evidenced by the following:</p> <p>a. A clinical document with the title of the physician and office dated 3/22/12</p>		<p>Records #2, #5, and #8. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. As the result of the findings of this survey, the agency is conducting inservice training for agency nurses and medical records staff 09/18/12- 09/25/12. The agenda for this deficiency will include: a) Review of 410 IAC 17-13-1(a)(1). 2.The administrative assistant managing medical records will monitor all active patient clinical records weekly for compliance with 410 IAC 17-13-1(a)(1). 3. The agency will make every effort to receive timely signatures from the ordering physician for the plan of care. The agency will instruct patients on admission regarding 410 IAC 17-13-1(a)(1)and agency cannot provide service without timely signatures from their physician. 4. The agency medical director will be informed when the ordering physician has not signed after 14 days to enlist assistance in obtaining the signed Plan of Care. 5. In the event the physician has not signed the Plan of Care in 30 days of the start date, services will be discharged. Both physician and patient will be kept informed throughout the procedure of the anticipated discharge date. 6. The QA team will audit 10% of clinical records quarterly for evidence of timely physician signatures on the plan of care and that the clinical record evidences all orders for treatments and equipment are</p>				

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	<p>and signed by the physician stated, "Mobile Suction Machine."</p> <p>b. A physician's order for a dressing order for a peg tube site was completed on 5/23/12.</p> <p>c. On 8/29/12 at 2:30 PM, Employee A indicated the wound care orders and suctioning machine were not listed on the plan of care.</p> <p>4. Clinical record #5, SOC 7/24/11, included a plan of care for the certification period of 7/18/12 - 9/15/12 that was not signed by the physician.</p> <p>On 8/29/12 at 3:05 PM, Employee A indicted the plan of care was not signed by the physician.</p> <p>5. Clinical record #8, SOC 12/10/11, included a plan of care for the certification period of 12/10/11 - 1/8/12 that was not signed by the physician.</p> <p>On 8/30/12 at 5:10 PM, Employee A indicated the plan of care was not signed by the physician.</p> <p>6. Clinical record #9, SOC 4/29/12, included a plan of care for the certification period 6/28/12 - 8/26/12 evidenced a plan of care that was not</p>		<p>included in Plans of care. Non-compliance will be reported to the Performance Improvement Team and the Director of Nursing. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157262	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/30/2012
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	<p>signed by the physician until 8/30/12.</p> <p>On 8/30/12 at 2:50 PM, Employee A indicated the plan of care was not signed until 8/30/12.</p> <p>7. The agency policy titled "Client Plan of Care" with the effective date of 9/13/93 stated, "The client plan of care A. is developed by the physician in consultation with the home health care staff and interdisciplinary team members B. includes the following ... (2) type of home health care services and equipment required."</p>				

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N0527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the doctor was informed on low blood sugar results for 1 of 2 patients (#1) with glucometer test assist noted on home health aide visit notes with the potential to affect all the agency's diabetic patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 6/29/12, failed to evidence the registered nurse contacted the physician with any low blood sugar results that were recorded at home health aide (HHA) visits</p> <p>a. The clinical document titled "Home Health Visit Report" signed by Employee H, HHA, on August 14 and 15, 2012, identified a glucometer test assists with blood sugars of 64 and 75 consecutively.</p> <p>b. The clinical document titled "Home Health Visit Report" signed by</p>	N0527	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. 'Family caregivers provides', will be listed on the Plan of Care for glucometer testing for patient #1. The physician is being notified in writing that this information was not included in the Plan of Care for the certification period of 6/29/12-08/27/12 and 08/28/12-10/26/12. This information will be included in continuing Plans of Care. 2. The agency is instructing patient /caregivers to inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 3. The Director of Nursing has instructed home health aides to stop entering the results of blood glucose test reported to them in their visit notes. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency is conducting inservice training for all agency staff 09/18/12-09/25/12. The agenda for this deficiency will include: a). Review</p>	09/29/2012			

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	<p>Employee K, HHA on August 13, August 16, and August 17, 2012, identified glucometer test assists with blood sugars of 67, 54 and 68 consecutively.</p> <p>c. On 8/30/12 at 10:50 AM, Employee A, director of nursing (DON), indicated the physician was not notified of the above blood sugars logged at the above visits.</p> <p>2. The agency policy titled "Skilled Nursing Services" with a date of 9/13/1993 stated, "The duties of the Home Health Care Registered Nurse include the following ... Informing physicians and home health care staff of changes in client conditions and needs."</p>		<p>of 410 IAC 17-13-1(a)(2) and agency policy and procedure for compliance with 410 IAC 17-13-1(a)(2). 2. The patient /caregivers will inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 3. Home health aides will no longer be instructed / allowed to enter results of blood glucose on their visit reports. 4. 10% of clinical records will be audited quarterly for compliance with 410 IAC 17-13-1(a)(2). The clinical nurse supervisor will report non-compliance to the Performance Improvement Team and the Director of Nursing who will take corrective actions.</p> <p>WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0532	<p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the doctor was informed on low blood sugar results for 1 of 2 patients (#1) with glucometer test assist noted on home health aide visit notes with the potential to affect all the agency's diabetic patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 6/29/12, failed to evidence the registered nurse contacted the physician with any low blood sugar results that were recorded at home health aide (HHA) visits</p> <p>a. The clinical document titled "Home Health Visit Report" signed by Employee H, HHA, on August 14 and 15, 2012, identified a glucometer test assists with blood sugars of 64 and 75 consecutively.</p>	N0532	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. 'Familycaregivers provides', will be listed on the Plan of Care for glucometer testing for patient #1. The physician is being notified in writing that this information was not included in the Plan of Care for the certification period of 6/29/12-08/27/12 and 08/28/12-10/26/12. This information will be included in continuing Plans of Care. 2. The agency is instructing patient /caregivers to inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 3. The Director of Nursing has instructed home health aides to stop entering the results of blood glucose test reported to them in their visit notes. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. The agency is</p>	09/29/2012			

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	<p>b. The clinical document titled "Home Health Visit Report" signed by Employee K, HHA on August 13, August 16, and August 17, 2012, identified glucometer test assists with blood sugars of 67, 54 and 68 consecutively.</p> <p>c. On 8/30/12 at 10:50 AM, Employee A, director of nursing (DON), indicated the physician was not notified of the above blood sugars logged at the above visits.</p> <p>2. The agency policy titled "Skilled Nursing Services" with a date of 9/13/1993 stated, "The duties of the Home Health Care Registered Nurse include the following ... Informing physicians and home health care staff of changes in client conditions and needs."</p>		<p>conducting inservice training for all agency staff 09/18/12-09/25/12. The agenda for this deficiency will include: a). Review of 410 IAC 17-13-1(d)and agency policy and procedure for compliance with 410 IAC 17-13-1(d). 2. The patient/caregivers will inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 3. Home health aides will no longer be instructed / allowed to enter results of blood glucose on their visit reports. 4. 10% of clinical records will be audited quarterly for compliance with 410 IAC 17-13-1(d).The clinical nurse supervisor will report non-compliance to the Performance Improvement Team and the Director of Nursing who will take corrective actions. WHO IS RESPONSIBLE TO ENSURE THAT THEDEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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N0542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure the registered nurse had obtained orders for blood sugar testing or assist and included all orders in the plan of care for 3 of 11 records reviewed (#1, #2, and #4) with the potential to affect all of the agency's current 24 patients.</p> <p>Findings:</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to test patient #1's blood sugar.</p> <p>a. Clinical record #1, start of care (SOC) 6/29/12, included a plan of care for the certification period of 6/29/12 - 8/27/12 that failed to evidence blood sugar testing was to be performed and that the registered nurse had updated the plan of care to include blood sugar testing.</p> <p>b. The aide care plan dated on</p>	N0542	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. 'Family caregivers provides', will be listed on the Plan of Care for glucometer testing for patient #1. The physician is being notified in writing that this information was not included in the Plan of Care for the certification period of 6/29/12-08/27/12 and 08/28/12-10/26/12. This information will be included in continuing Plans of Care. 2. The agency is instructing patient /caregivers to inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 3. The Director of Nursing has instructed home health aides to stop entering the results of blood glucose test reported to them in their visit notes. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency is conducting inservice training for all agency staff 09/18/12-09/25/12. The agenda for this</p>	09/29/2012			

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	<p>6/29/12 and signed by Employee A on 6/29/12 stated, "Assist Glucometer testing."</p> <p>c. On 8/30/12 at 10:50 AM, Employee A indicated the plan of care had not been updated to include the blood sugar testing.</p> <p>2. Clinical record #2, SOC 12/19/10, included plans of care for the certification periods of 6/11/12 - 8/9/12 and 8/10/12 - 10/6/12 that failed to evidence blood sugar testing or assist was to be performed by the aide or that the registered nurse had contacted the physician for orders for blood sugar testing.</p> <p>a. The clinical document titled "Home Health Visit report" dated 8/16/12 and signed by Employee H, HHA, identified a checked box with glucometer test assist and blood sugar of 99.</p> <p>b. The clinical document titled "Home Health Visit report" signed by Employee N, HHA, dated 8/14/12, 8/15/12, and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter (mg/dl).</p> <p>c. The clinical document titled "Home Health Visit report" signed by</p>		<p>deficiency will include: a). Review of 410 IAC 17-13-1(d) and agency policy and procedure for compliance with 410 IAC 17-13-1(d). 2. The patient/caregivers will inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 3. Home health aides will no longer be instructed / allowed to enter results of blood glucose on their visit reports. 4. 10% of clinical records will be audited quarterly for compliance with 410 IAC 17-13-1(d). The clinical nurse supervisor will report non-compliance to the Performance Improvement Team and the Director of Nursing who will take corrective actions.</p> <p>WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED</p> <p>The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>employee N dated 8/4/12, 8/5/12, 8/6/12, and 8/8/12 listed blood sugars of 79, 98, 94, and 80 mg /dl.</p> <p>d. On 8/30/12 at 11 AM, Employee A indicated that no additional orders for updating the plan of care had been requested.</p> <p>3. Clinical record #4, SOC 12/10/10, included a plan of care for the certification period of 8/11/12 - 10/9/12 that failed to evidence the nurse had updated the plan of care to include wound care and a suction machine.</p> <p>a. A clinical document with the title of the physician and office dated 3/22/12 and signed by the physician stated, "Mobile Suction Machine." This order was not included on the plan of care.</p> <p>b. A physician's order for a dressing order for a peg tube site was completed on 5/23/12. This order was not included on the plan of care.</p> <p>c. On 8/29/12 at 2:30 PM, Employee A indicated the registered nurse had not updated the plan of care with the wound care orders and suctioning machine orders.</p> <p>4. The agency policy titled "Client Plan</p>			

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	of Care" with an effective date of 9/13/1993 stated, "The client plan of care is developed by a physician in consultation with the home health care staff and interdisciplinary team members ... Changes in the plan of care are documented through written plans of modifications, or, if the changes are requested orally, are reduced to writing, signed by a Home Health Care Registered Nurse, and countersigned by the attending physician as soon as possible."				

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N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse coordinated care with other entities that had provided services in 1 of 3 clinical records reviewed (clinical record 5) of patients receiving additional services from other entities.</p> <p>Findings</p> <p>1. Clinical record #5, SOC 7/24/11, included a plan of care for the certification period of 7/18/12 - 9/15/12 that identified the patient received the services of a speech therapist and physical therapist. No documentation was present to show care coordination with these outside entities. This was evidenced by the following:</p> <p style="padding-left: 40px;">A. A nursing note signed by Employee F, Licensed Practical Nurse, with a date of 7/24/12 from 2 PM - 8 PM stated, "Physical therapist here to eval [evaluate] and treat ... Speech therapist</p>	N0545	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. The caregiver for patient #5 has been contacted to discuss the 410 IAC 17-14-1(a)(1)(F).The caregiver and the physician was informed in writing that the agency cannot continue to provide care for patient #5 unless care can be coordinated with the physical therapist and the speech therapist providing care for patient # 5. 2. The physician is being notified in writing that the physical and speech therapist providing care for this patient should have been included in the plan of carefor certification period 07/18/12 – 09/15/12. The physician is being notified inwriting that agency is attempting to coordinate care with the physical andspeech therapist and the need to discharge patient if care coordination cannotbe achieved. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. As the result of the findings of this survey, the agency is conducting inservice training for all agency staff 09/18/12-09/25/12. The agenda for this deficiency will include: a). 410 IAC 17-14-1(a)(1)(F) and agency policy for compliance with 410</p>	09/29/2012	

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	<p>here to eval and treat. Notified of pt. [patient] difficulty with chopped steak lunch given on 7/22/12. Made aware of coughing episode. States 'I will follow up with family. Re: food consistency.' "</p> <p>B. On 8/29/12 at 4:10 PM, Employee A indicated the patient's caregiver had requested therapy and hired private therapists to care for the patient.</p> <p>2. The agency policy titled "Care Coordination Policy no. 2 -025.1" with an effective date of 9/21/07 stated, "To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services ... Timely and ongoing communication is the responsibility of each team member, will be appropriate to the needs and abilities of the patient, and will be relevant to the care provided ... Written evidence of care coordination will be recorded during the case conference and repeated in skilled nursing visits in the patient's clinical records ... Care coordination will include, but not be limited to ... E. timely documentation of coordination of care activities F. Appropriate involvement of the patient and caregivers ... 8. Written of evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patient's</p>		<p>IAC 17-14-1(a)(1)(F). 2. The agency will inform all patients /caregivers in writing of 410 IAC 17-14-1(a)(1)(F) and agency policy and procedures at patient's admission to the agency. 3. Upon learning of other entities or individuals providing care for agency patients, agency will remind & review 410 IAC 17-14-1(a)(1)(F) and agency procedure regarding this rule with the patient /caregiver. The agency will notify the patient /caregiver and the physician of plans to discharge patient or make every effort to contact the other entity to coordinate services with that entity if this is a workable solution. If agency is unsuccessful after 5 days, the agency will inform the patient and the ordering physician that agency must discharge the patient. 4. 10% of clinical records will be audit by QA team quarterly to note evidence of care coordination and that this is appropriately integrated into the clinical record. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0546	<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 and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the doctor was informed on low blood sugar results for 1 of 2 patients (#1) with glucometer test assist noted on home health aide visit notes with the potential to affect all the agency's diabetic patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 6/29/12, failed to evidence the registered nurse contacted the physician with any low blood sugar results that were recorded at home health aide (HHA) visits</p> <p>a. The clinical document titled "Home Health Visit Report" signed by Employee H, HHA, on August 14 and 15, 2012, identified a glucometer test assists with blood sugars of 64 and 75</p>			N0546	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. 'Family caregivers provides', will be listed on the Plan of Care for glucometer testing for patient #1. The physician is being notified in writing that this information was not included in the Plan of Care for the certification period of 6/29/12-08/27/12 and 08/28/12-10/26/12. This information will be included in continuing Plans of Care. 2. The agency is instructing patient /caregivers to inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 3. The Director of Nursing has instructed home health aides to stop entering the results of blood glucose test reported to them in their visit notes. TO ENSURE THIS</p>		09/29/2012

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	<p>consecutively.</p> <p>b. The clinical document titled "Home Health Visit Report" signed by Employee K, HHA on August 13, August 16, and August 17, 2012, identified glucometer test assists with blood sugars of 67, 54 and 68 consecutively.</p> <p>c. On 8/30/12 at 10:50 AM, Employee A, director of nursing (DON), indicated the physician was not notified of the above blood sugars logged at the above visits.</p> <p>2. The agency policy titled "Skilled Nursing Services" with a date of 9/13/1993 stated, "The duties of the Home Health Care Registered Nurse include the following ... Informing physicians and home health care staff of changes in client conditions and needs."</p>		<p>DEFICIENCY WILL NOT RECUR</p> <p>1. The agency is conducting inservice training for all agency staff 09/18/12-09/25/12. The agenda for this deficiency will include: a). Review of 410 IAC 17-14-1(a)(1)(G) and agency policy and procedure for compliance with 410 IAC 17-14-1(a)(1)(G). 2. The patient /caregivers will inform the nurse of blood glucose results and not the home health aide. Ranges for intervention and types of interventions approved by the physician will be identified in The Plan of Care. The nurse will report abnormal blood glucose levels to the physician appropriately. 3. Home health aides will no longer be instructed / allowed to enter results of blood glucose on their visit reports. 4. 10% of clinical records will be audited quarterly for compliance with 410 IAC 17-14-1(a)(1)(G). The clinical nurse supervisor will report non-compliance to the Performance Improvement Team and the Director of Nursing who will take corrective actions.</p> <p>WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED</p> <p>The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review, home visit observation, interview, personnel file review, and policy review, the agency failed to ensure the registered nurse appropriately assigned glucose testing or assist as part of the aide's tasks for 2 of 2 records reviewed where the aide completed glucose test or assist (#1 and 2) with the potential to affect any of the agency's 24 patients who have glucometer test assist performed at home health aide visits.</p> <p>Findings</p> <p>1. Clinical record #1, start of care 6/29/12 with a certification period of 6/29/12 - 8/27/12 contained a Home Health Aide Care plan dated 6/29/12. Under the section titled Tasks, the RN assigned assist glucometer testing to be done during each visit by home health aides.</p>	N0550	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The agency completes competency testing for tasks within the home health aide scope of practice as outlined in 484.36 Condition of participation: Home health aide services. Agency categorized recording blood glucose as (ii) Observation, reporting and documentation of patient status and the care or service furnished. Agency will categorize this as any other task that the HHA may choose to have the home health aide perform before additional task can be assigned / performed which must be in home health aide scope of practice. Agency home health aides have been instructed to cease writing results oof blood sugars reported to them in their visit notes. 2. Registered nurses are being inserviced regarding appropriately assigning home health aides to document any additional types of information. The home health aide will be specifically competency tested under any other task that the HHA may choose to have the home health</p>	09/29/2012			

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	<p>a. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to perform blood sugar testing for Patient #1. Personnel File H, date of hire 8/16/03 and first patient contact 8/25/03, failed to evidence competency training with glucometer test assist.</p> <p>The clinical document titled "Home Health Visit Report" signed by Employee H on August 14 and 15, 2012, listed a glucometer test assists with blood sugars of 64 and 75 consecutively.</p> <p>b. The clinical document titled "Home Health Visit Report" for patient #1 signed by Employee K, HHA, on August 13, August 16, and August 17, 2012, listed glucometer test assists with blood sugars of 67, 54, and 68 consecutively. Personnel File K, HHA, date of hire 5/4/09 and first patient contact 5/8/09, failed to evidence competency training with glucometer test assist.</p> <p>2. The aide care plan dated 2/11/12 by Employee A included glucometer test assist to be completed by the HHA at every visit. Clinical record #2 failed to evidence an order for glucometer test assist.</p>		<p>aide perform. 3. Before assigning task on the home health aide care plan, registered nurses will ensure with the Director of Nursing that home health aides are competency tested to perform the task. 4. Agency competency testing for home health aides does not include glucometer testing or glucometer assisting. 5. The registered nurses have been instructed to delete the glucometer check results from existing home health aide care plans. 6. The registered nurse will review the current care plans with Employee H, Employee K and Employee N to instruct changes. 7. The registered nurse will instruct all home health aides and agency patients / caregivers regarding these changes. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency is conducting inservice training for all agency registered nurses 09/18/12- 09/25/12. The agenda will include: 410 IAC 17-14-1(a)(1)(K) and agency policy and procedure for compliance with 410 IAC 17-14-1(a)(1)(K). 2. Home health aides will not be allowed to write any results reported to them on their visit reports unless specifically competency tested for the task. The nurse will obtain information regarding competency testing from the Director of Nursing. 3. Home health aides will not be</p>				

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	<p>a. The clinical document titled "Home Health Visit report" for patient #2 signed by Employee N, HHA with a dates of 8/14/12, 8/15/12 and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter(mg/dl). The clinical document titled "Home Health Visit report" for patient #2 signed by employee N with the dates of 8/4/12, 8/15/12, 8/6/12 and 8/8/12 indicated blood sugars of 79, 98, 94, and 80 mg /dl. Personnel File N, HHA, date of hire 11/11/11 and first patient contact 11/12/11, failed to evidence competency training with glucometer test assist.</p> <p>3. On 8/28/12 at 10:30 AM, Employee A indicated the agency home health aides listed above had not been competency tested on glucometer assist or glucometer testing and were not to assist or complete glucometer testing.</p> <p>4. The agency policy titled "Home Health Aide Services" with an effective date of 9/13/1993 stated, "The home health care agency provides Home Health Aide services as appropriate ... Home Health aides are carefully trained in ... any other task that the home health care agency may choose to have the home health aide perform ... The Home Health Care Registered Nurse gives written instructions for client care to the Home</p>		<p>allowed to perform glucometer testing. 4. Home health aides will not be instructed / allowed to perform glucometer assist. 5. Home Health Supervisory Visits will have an increased focus on scope of practice. 6. The Performance Improvement Team will monitor these changes to ensure compliance. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	Health aide as appropriate."				

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N0596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and</p> <p>Based on clinical record review, home visit observation, interview, personnel file review, and policy review, the agency failed to ensure 3 of 7 home health aide files (H, K, and N) reviewed identified the aide was competent to perform glucose testing or assist with the potential to affect any of the agency's 24 patients who have glucometer test assist performed at home health aide visits.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to perform blood sugar testing for Patient #1. Personnel File H, date of hire 8/16/03 and first patient contact 8/25/03, failed to evidence competency training with glucometer test assist. The clinical document titled "Home</p>	N0596	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. The agency completes competency testing for tasks within the home health aide scope of practice as outlined in 484.36 Condition of participation: Home health aide services. Agency categorized recording blood glucose as (ii) Observation, reporting and documentation of patient status and the care or service furnished. Agency will categorize this as any other task that the HHA may choose to have the home health aide perform. Agency home health aides have been instructed to cease writing results from reports of glucometer testing in their visit notes. 2. Registered nurses are being inserviced regarding appropriately assigning home health aides to document any additional types of information. The home health aide will be specifically competency tested under any other task that the HHA may choose to have the home health aide perform. 3. Before</p>	09/29/2012			

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	<p>Health Visit Report" signed by Employee H on August 14 and 15, 2012, listed a glucometer test assists with blood sugars of 64 and 75 consecutively.</p> <p>2. The clinical document titled "Home Health Visit Report" for patient #1 signed by Employee K, HHA, on August 13, August 16, and August 17, 2012, listed glucometer test assists with blood sugars of 67, 54, and 68 consecutively. Personnel File K, HHA, date of hire 5/4/09 and first patient contact 5/8/09, failed to evidence competency training with glucometer test assist.</p> <p>2. The clinical document titled "Home Health Visit report" for patient #2 signed by Employee N, HHA with a dates of 8/14/12, 8/15/12 and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter(mg/dl). The clinical document titled "Home Health Visit report" for patient #2 signed by employee N with the dates of 8/4/12, 8/15/12, 8/6/12 and 8/8/12 indicated blood sugars of 79, 98, 94, and 80 mg /dl. Personnel File N, HHA, date of hire 11/11/11 and first patient contact 11/12/11, failed to evidence competency training with glucometer test assist.</p> <p>3. On 8/28/12 at 10:30 AM, Employee A indicated the agency home health aides</p>		<p>assigning task on the home health aide care plan, registered nurses will ensure with the Director of Nursing that home health aides are competency tested to perform the task. 4. Agency competency testing for home health aides does not include glucometer testing or glucometer assisting. 5. The registered nurses have been instructed to delete the glucometer check results from existing home health aide care plans. 6. The registered nurse will review the current care plans with Employee H, Employee K and Employee N to instruct changes. 7. The registered nurse will instruct all home health aides and agency patients /caregivers regarding these changes. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. The agency is conducting inservice trainingfor all agency registered nurses 09/18/12- 09/25/12. The agenda will include: 410IAC 17-14-1(a)(l) (A) and agencypolicy and procedure for compliance with 410 IAC 17-14-1(a)(l)(A). 2. Home health aides will not be allowed to write any results reported to them on their visit reports unless specifically competency tested for the task. The nurse will obtain information regarding competency testing from the Director of Nursing. 3. Home health aides will not be instructed / allowed to perform</p>		

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	<p>listed above had not been competency tested on glucometer assist or glucometer testing and were not to assist or complete glucometer testing.</p> <p>4. The agency policy titled "Home Health Aide Services" with an effective date of 9/13/1993 stated, "The home health care agency provides Home Health Aide services as appropriate ... Home Health aides are carefully trained in ... any other task that the home health care agency may choose to have the home health aide perform."</p>		<p>glucometer testing. 4. Home health aides will not be instructed / allowed to perform glucometer assist. 5. The Performance Improvement Team will monitor these changes to ensure compliance. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0603	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide may not be assigned to perform additional tasks not included in the original competency evaluation until he or she has successfully been evaluated as competent in that task.</p> <p>Based on clinical record review, home visit observation, interview, personnel file review, and policy review, the agency failed to ensure 3 of 7 home health aide files (H, K, and N) reviewed identified the aide was competent to perform glucose testing or assist with the potential to affect any of the agency's 24 patients who have glucometer test assist performed at home health aide visits.</p> <p>Findings</p> <p>1. On 8/28/12 at 10:10 AM, Employee H, home health aide (HHA), was observed to perform blood sugar testing for Patient #1. Personnel File H, date of hire 8/16/03 and first patient contact 8/25/03, failed to evidence competency training with glucometer test assist.</p> <p>The clinical document titled "Home Health Visit Report" signed by Employee H on August 14 and 15, 2012, listed a glucometer test assists with blood sugars of 64 and 75 consecutively.</p>	N0603	<p>HOW THE DEFICIENCY WILL BE CORRECTED</p> <p>1. The agency completes competency testing for tasks within the home health aide scope of practice as outlined in 484.36 Condition of participation: Home health aide services. Agency believed recording blood glucose was (ii) Observation, reporting and documentation of patient status and the care or service furnished. Agency will categorize this as any other task that the HHA may choose to have the home health aide perform.</p> <p>2. Registered nurses are being inserviced regarding appropriately assigning home health aides to document any additional types of information. The home health aide will be specifically competency tested under any other task that the HHA may choose to have the home health aide perform before additional tasks can be assigned / instructed which must be in home health aides scope of practice.</p> <p>3. Before assigning task on the home health aide care plan, registered nurses will ensure with the Director of Nursing that home health aides are competency tested to perform the task.</p> <p>4.</p>	09/29/2012	

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	<p>2. The clinical document titled "Home Health Visit Report" for patient #1 signed by Employee K, HHA, on August 13, August 16, and August 17, 2012, listed glucometer test assists with blood sugars of 67, 54, and 68 consecutively. Personnel File K, HHA, date of hire 5/4/09 and first patient contact 5/8/09, failed to evidence competency training with glucometer test assist.</p> <p>2. The clinical document titled "Home Health Visit report" for patient #2 signed by Employee N, HHA with a dates of 8/14/12, 8/15/12 and 8/17/12 listed blood sugars of 97, 93, and 98 milligram per deciliter(mg/dl). The clinical document titled "Home Health Visit report" for patient #2 signed by employee N with the dates of 8/4/12, 8/15/12, 8/6/12 and 8/8/12 indicated blood sugars of 79, 98, 94, and 80 mg /dl. Personnel File N, HHA, date of hire 11/11/11 and first patient contact 11/12/11, failed to evidence competency training with glucometer test assist.</p> <p>3. On 8/28/12 at 10:30 AM, Employee A indicated the agency home health aides listed above had not been competency tested on glucometer assist or glucometer testing and were not to assist or complete glucometer testing.</p>		<p>Agency competency testing for home health aides does not include glucometer testing or glucometer assisting. 5. The registered nurses have been instructed to delete the glucometer check results from existing home health aide care plans. 6. The registered nurse will review the current care plans with Employee H, Employee K and Employee N to instruct changes. 7. The registered nurse will instruct all home health aides and agency patients / caregivers regarding these changes. TO ENSURE THIS DEFICIENCY WILL NOT RECUR</p> <p>1. The agency is conducting inservice training for all agency registered nurses 09/18/12-09/25/12. The agenda will include: 410 IAC 17-14-1(m)and agency policy and procedure for compliance with 410 IAC 17-14-1(m). 2. Home health aides will not be allowed to write any results reported to them on their visit reports unless specifically competency tested for the task. The nurse will obtain information regarding competency testing from the Director of Nursing. 3. Home health aides will not be allowed to perform glucometer testing. 4. Home health aides will not be instructed / allowed to perform glucometer assist. 5. The Performance Improvement Team will monitor these changes to ensure compliance. WHO IS</p>				

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	4. The agency policy titled "Home Health Aide Services" with an effective date of 9/13/1993 stated, "The home health care agency provides Home Health Aide services as appropriate ... Home Health aides are carefully trained in ... any other task that the home health care agency may choose to have the home health aide perform."		RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days as required by agency policy for 1 of 2 records reviewed (#11) of patients receiving home health aide and skilled nurse services with the potential to affect all the patients who receive skilled nurse and home health aide services.</p> <p>Findings</p> <p>1. Clinical record #11, start of care 5/29/12, included a plan of care for the certification period 5/29/12 - 7/27/12 with orders for skilled and home health aide services. The record failed to evidence any documentation of supervisory visits for the home health aide services except on 7/10/12.</p> <p>2. On 8/30/12 at 5:10 PM Employee A</p>			N0606	<p>HOW THE DEFICIENCY WILL BE CORRECTED 1. As the result of the findings of this survey, the agency is conducting inservice training for agency registered nurse staff and scheduling department staff. Theagenda for this deficiency will include: a) Review of compliance with 410 IAC17-14-1(n). and AgencyPolicy and Procedure for compliance with 410 IAC 17-14-1(n). 2. Additional procedures for scheduling and monitoring of home health supervisory visits to ensure compliance will be added. TO ENSURE THIS DEFICIENCY WILL NOTRECUR 1. All Home Health Aide Supervisory visits will be scheduled by the scheduling departmentin compliance with 410 IAC 17-14-1(n). The registered nurses will receive acopy of the supervisory visit schedule for home health aides. The scheduling department will monitor the completion of the supervisory visits, and reportnon-compliance to the Director of Nursing. 2. 10% ofclinical records will be audited</p>		09/29/2012

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	<p>indicated there was no additional documentation to evidence home health aide supervisory visits.</p> <p>3. The agency policy titled "Home Health Aide supervisory visits" with an effective date of 9/13/93 stated, "A Home Health Care Registered Nurse makes a Home Health Aide supervisory visit to the client residence at least every two weeks, either when the Home Health Aide is present to observe and assist, or when the Home Health Aide is absent ... "</p>		<p>by QA team quarterly to note compliance with 410 IAC 17-14-1(n). The QA team will report this information to the Director of Nursing and the Performance Improvement Team.</p> <p>WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED</p> <p>The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure 1 of 4 closed records reviewed (#8) contained signed and dated progress notes with the potential to affect all the patient records of the agency.</p> <p>Findings</p> <p>1. On 8/30/12 at 10:10 AM, clinical record #8, start of care 12/10/11 and discharge date of 1/21/12, was requested.</p> <p>2. On 8/30/12 at 2:35 PM, Clinical record #8 was requested for the third time. This record presented failed to include signed</p>	N0608	<p>HOW THE DEFICIENCY WILL BE CORRECTED The progress notes for Clinical record #8 were located in a thinned file and both files were merged into one. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. As the result of the findings of this survey, the agency is conducting inservice training for agency medical records staff. The agenda for this deficiency will include: a) Review of 410 IAC 17-15-1(a)(1-6)and Agency Policy and Procedure for compliance with IAC 17-15-1(a)(1-6). 2. The Director of Nursing will establish a section in the clinical record to identify thinned files (content and location) to improve timely access</p>	09/29/2012			

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	<p>and dated clinical progress notes.</p> <p>3. On 8/30/12 at 2:35 PM, Employee A, the administrator and director of nursing, indicated the above record was incomplete. Employee A stated, "I looked in the record room and was not able to find the entire record."</p> <p>4. The agency policy titled "Client Clinical Record" with an effective date of 9/13/1993 stated, "Client clinical records are maintained in accordance with professional standards. Client clinical records contain ... signed and dated client clinical notes written on the day service is rendered, ... g. signed and dated client progress notes."</p>				<p>of the entire file. The Director of Nursing will re-instruct medical records staff regarding parts of the clinical record which can be thinned due to overflow and parts which should continuously remain in the main file. WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0614	<p>410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the clinical record was safeguarded against loss for 1 of 4 closed records reviewed (#8) with the potential to affect all the patient records of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> On 8/30/12 at 10:10 AM, clinical record #8, start of care 12/10/11 and discharge date of 1/21/12, was requested. On 8/30/12 at 2:35 PM, Clinical record #8 was requested for the third time. This record presented failed to include signed and dated clinical progress notes. 	N0614	<p>HOW THE DEFICIENCY WILL BE CORRECTED The progress notes for Clinical record #8 were located in a thinned file and both files were merged into one. TO ENSURE THIS DEFICIENCY WILL NOT RECUR 1. As the result of the findings of this survey, the agency is conducting inservice training for agency medical records staff. The agenda for this deficiency includes: a) Review of IAC 17-15-1(c) and Agency Policy and Procedure for compliance with IAC 17-15-1(c). 2. The Director of Nursing will establish a section in the clinical record to identify thinned files (content and location) to improve timely access of the entire file. The Director of Nursing will re-instruct medical records staff regarding parts of</p>	09/29/2012			

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	<p>3. On 8/30/12 at 2:35 PM, Employee A, the administrator and director of nursing, indicated the above record was incomplete. Employee A stated, "I looked in the record room and was not able to find the entire record."</p> <p>4. The agency policy titled "Client Clinical Record" with an effective date of 9/13/1993 stated, "Client clinical records are maintained in accordance with professional standards. ... Client clinical records are retained and protected."</p>		<p>the clinical record which can be thinned due to overflow and parts which should continuously remain in the main file. 3. 10% of clinical records will be audit by QA team quarterly to note evidence of appropriate storage of clinical records to remain in compliance with IAC 17-15-1(c). WHO IS RESPONSIBLE TO ENSURE THAT THE DEFICIENCY WILL BE/HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		