

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/16/2012
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NAME OF PROVIDER OR SUPPLIER RELIABLE HOME HEALTHCARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 6801 LAKE PLAZA DRIVE, SUITE A107 INDIANAPOLIS, IN 46220
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G0000	<p>This visit was a Home Health Initial Medicaid certification survey. This was a partial extended survey.</p> <p>Survey Dates: November 15 and 16, 2012</p> <p>Facility Number: 012999</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 10 Home Health Aide Only: 0 Personal Care Only: 0 Total: 10</p> <p>Sample: RR w/HV: 1 RR w/o HV: 9 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 21, 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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G0139	<p>484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).</p> <p>This person, or similarly qualified alternate, is available at all times during operating hours.</p> <p>Based on policy review, observation, and interview, the agency failed to ensure an administrator or qualified alternate was available at all times during operating hours for 1 of 1 agency reviewed with the potential to effect all 7 active patients of this agency.</p> <p>Findings:</p> <p>1. Facility policy titled "After Hours Care" document number 3.013.1, undated states,"Upon admission, all agency patients will be made aware that normal business hours are 9 a.m.-5 p.m. M-F [Monday through Friday]. After 5:00, the on-call person will take a message and relay the information to the RN on call as needed."</p> <p>2. On 11/15/12 at 9:15 AM, upon arrival to facility, the door was locked. The</p>			G0139	<p>The Administrator/designee will ensure the office number rolls over to the on-call person after hours and if the office person should have to step away from office. Immediately</p> <p>Administrator/designee will instruct staff that when on-call they need to check for voicemails regularly. Immediately</p> <p>Administrator/designee will instruct staff that when on-call they are to return calls within 30 minutes or less. Immediately</p> <p>On-call policy has been updated by Consultant to add "calls will be returned in 30 minutes or as soon as the person is able to return call." 11/23/12 (See attachment) Director of Nursing/designee will include review of the on-call policy as part of orientation of newly hired nurses. On-going</p>		11/23/2012

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	<p>number listed on agency door and provided to the Indiana State Department of Health (ISDH) was (317) 841-0630. The office hours listed on the door was from 9:00 AM to 5:00 PM.</p> <p>On 11/15/12 at 9:23 AM, phone call was placed to reach agency, voicemail prompted, and message left. No call was returned as of 11:15 AM.</p> <p>3. On 11/15/12 at 11:30 AM, employee B, owner, indicated the agency's phone number is on the agency door, and, when calls are made after hours, they are routed to employee's cell phone. Employee further indicated voicemail is checked regularly. Employee could not explain why voicemail that was left at 9:15 AM was not returned</p> <p>4. On 11/15/12 at 12:30 PM, during Entrance Conference, employee E, Registered Nurse, indicated calls are received by employee B, owner, who is then is responsible for routing to responsible personnel. Employee E indicated that someone should always be available to take call for the agency, and calls need to be returned within 10 to 15 minutes.</p>			

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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 policy review, clinical record review, and interview, the home health agency failed to provide skilled nursing services and home health aide services in accordance with the plan of care in 5 of 7 active records reviewed with the potential to affect all the agency's patients. (#1, 2, 4, 5, and 7).</p> <p>The findings include:</p> <p>1. Facility policy titled "Nurse Supervision" document number 6.020.1, undated states,"1. The supervising nurse will routinely review the POC and all subsequent orders and review notes to ensure that the POC is directly being followed and all orders have been signed by the physician. The nurse will also notify the office manager if orders have not been received by the physician in order to ensure that the physician orders be obtained and filed within 60 days ... 3. The supervising nurse will ensure that the patients POC is being followed through chart audits, note reviews, staff</p>			G0158	<p>The policy on Nursing Supervision (6.020.1) has been revised by the Consultant to correct who is responsible for tracking MD orders. 11/23/12 (See attachment)</p> <p>Current nursing staff will be in-serviced by Director of Nursing/designee on policy for Nursing Supervision. 11/30/12</p> <p>Director of Nursing/designee will in-service newly hired nurses on the Policy for Nursing Supervision as part of their orientation. On-going</p> <p>Director of Nursing/designee will review 100% of visit documentation to ensure the Plan of Care is being followed until 100% compliance is achieved. On-going</p> <p>Once 100% compliance is achieved, Director of Nursing/designee will audit 10% of documentation weekly to ensure the Plan of Care is being followed. On-going</p> <p>Director of Nursing/designee will include in orientation of newly hired nurses the requirement to follow</p>		11/30/2012

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	<p>communication and client communication."</p> <p>2. Clinical record #1, start of care 10/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/12/12 to 12/10/12 with orders that state, "Assess Cardiovascular status ... Assess and Instruct s/s [signs and symptoms] of Hypo/Hyperglycemia." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/18/12, employee E, Registered Nurse, failed to assess for hypo/hyperglycemia. The section of the Nursing Assessment titled "Endocrine" was left blank.</p> <p>B. On 10/25/12, employee E, Registered Nurse, failed to assess for cardiovascular status. The section of the Nursing Assessment titled "Chest Pain" was left blank.</p> <p>C. On 11/14/12, employee D, Registered Nurse, failed to assess for hypo / hyperglycemia. The section of the Nursing Assessment titled "Endocrine" was left blank.</p> <p>D. On 11/16/12 at 5:50 PM, employee E,</p>		<p>the Plan of Care and document according to the Plan of Care. On-going</p> <p>Director of Nursing/designee will audit 20% of charts monthly to ensure visit frequency is being followed or there is a missed visit report. On-going</p>				

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	<p>Registered Nurse, indicated these sections were not completed.</p> <p>3. Clinical record #2, start of care 10/01/12, included an order dated 10/18/12 for Home Health Aide (HHA) to begin on 10/18/12 up to 2 hours for 2 days per week. Beginning on 10/22/12, the order states the HHA reports 2 hours per day for 5 days per week. The week of 10/18/12 no HHA visits were made. The week of 10/22/12, only 2 HHA visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>On 11/16/12 at 6:15 PM, employee E, Registered Nurse, indicated the visits were not in the chart.</p> <p>4. Clinical record #4, start of care 10/3/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/3/12 to 12/1/12 with orders that state, "Assess VS [Vital Signs] ... Assess, Perform, Instruct Fluid intake." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/10/12, 10/16/12, 10/23/12, 10/30/12, 11/6/12, 11/13/12, employee</p>						

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	<p>E, Registered Nurse, failed to assess for fluid intake.</p> <p>B. On 10/30/12, employee E, Registered Nurse, failed to assess all vital signs. Temperature and Respirations were not documented.</p> <p>5. Clinical record #5, start of care 10/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/5/12 to 12/3/12 with orders that state, "Assess VS." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/10/12, employee E, Registered Nurse, failed to assess Temperature.</p> <p>B. On 10/25/12, employee E, Registered Nurse, failed to assess Blood Pressure.</p> <p>6. Clinical record #7, start of care 9/28/12, included a Home Health Certification and Plan of Care for the Certification Period from 9/28/12 to 11/26/12 with orders for Skilled Nursing 1 time per week for 9 weeks. The record failed to evidence all scheduled Skilled Nursing visits were made as ordered. The week of 10/22/12 and 10/29/12 no Skilled Nursing visits were made. There were no missed visit notes or evidence</p>						

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	the doctor was notified of the missed visits in the record.			

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G0170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to provide skilled nursing services in accordance with the plan of care in 4 of 7 active records reviewed with the potential to affect all the agency's patients that receive skilled nurse services. (#1, 4, 5, and 7).</p> <p>The findings include:</p> <p>1. Facility policy titled "Nurse Supervision" document number 6.020.1, undated states, "1. The supervising nurse will routinely review the POC and all subsequent orders and review notes to ensure that the POC is directly being followed and all orders have been signed by the physician. The nurse will also notify the office manager if orders have not been received by the physician in order to ensure that the physician orders be obtained and filed within 60 days ... 3. The supervising nurse will ensure that the patients POC is being followed through chart audits, note reviews, staff communication and client communication."</p>	G0170	<p>The policy on Nursing Supervision (6.020.1) has been revised by the Consultant to correct who is responsible for tracking MD orders. 11/23/12 (See attachment)</p> <p>Director of Nursing/designee will track MD orders using a tracking tool. 11/30/12 (See attachment)</p> <p>Director of Nursing/designee will follow MD order tracking policy. 11/30/12 (See attachment)</p> <p>Current nursing staff will be in-serviced by Director of Nursing/designee on policy for Nursing Supervision. 11/30/12</p> <p>Director of Nursing/designee will in-service newly hired nurses on the Policy for Nursing Supervision as part of their orientation. On-going</p> <p>Director of Nursing/designee will review 100% of visit documentation to ensure the Plan of Care is being followed until 100% compliance is achieved. On-going</p> <p>Once 100% compliance is achieved, Director of Nursing/designee will audit 10% of documentation weekly to ensure the Plan of Care is being</p>	11/30/2012			

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	<p>2. Clinical record #1, start of care 10/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/12/12 to 12/10/12 with orders that state, "Assess Cardiovascular status ... Assess and Instruct s/s [signs and symptoms] of Hypo/Hyperglycemia." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/18/12, employee E, Registered Nurse, failed to assess for hypo/hyperglycemia. The section of the Nursing Assessment titled "Endocrine" was left blank.</p> <p>B. On 10/25/12, employee E, Registered Nurse, failed to assess for cardiovascular status. The section of the Nursing Assessment titled "Chest Pain" was left blank.</p> <p>C. On 11/14/12, employee D, Registered Nurse, failed to assess for hypo / hyperglycemia. The section of the Nursing Assessment titled "Endocrine" was left blank.</p> <p>D. On 11/16/12 at 5:50 PM, employee E, Registered Nurse, indicated these sections were not completed.</p>		<p>followed. On-going</p> <p>Director of Nursing/designee will include in orientation of newly hired nurses the requirement to follow the Plan of Care and document according to the Plan of Care. On-going</p> <p>Director of Nursing/designee will audit 20% of charts monthly to ensure visit frequency is being followed or there is a missed visit report. On-going</p>				

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	<p>3. Clinical record #4, start of care 10/3/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/3/12 to 12/1/12 with orders that state, "Assess VS [Vital Signs] ... Assess, Perform, Instruct Fluid intake." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/10/12, 10/16/12, 10/23/12, 10/30/12, 11/6/12, 11/13/12, employee E, Registered Nurse, failed to assess for fluid intake.</p> <p>B. On 10/30/12, employee E, Registered Nurse, failed to assess all vital signs. Temperature and Respirations were not documented.</p> <p>4. Clinical record #5, start of care 10/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/5/12 to 12/3/12 with orders that state, "Assess VS." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/10/12, employee E, Registered Nurse, failed to assess Temperature.</p> <p>B. On 10/25/12, employee E, Registered Nurse, failed to assess Blood Pressure.</p>			

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	<p>5. Clinical record #7, start of care 9/28/12, included a Home Health Certification and Plan of Care for the Certification Period from 9/28/12 to 11/26/12 with orders for Skilled Nursing 1 time per week for 9 weeks. The record failed to evidence all scheduled Skilled Nursing visits were made as ordered. The week of 10/22/12 and 10/29/12 no Skilled Nursing visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p>			

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G0337	<p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the medication review was updated and accurate when there were medication changes in 2 of 7 active clinical records reviewed with the potential to effect all patients at this agency. (#1 and #3)</p> <p>Findings include:</p> <p>1. The policy titled "Medication Administration Record" policy number 4.009.2, undated states, "A MAR [Medication Administration Record] will be filled out for each patient whom receives medication administration by a skilled nurse. All nursing staff are required to document on the MAR the following information: a) medications, b) dose."</p> <p>2. Clinical record #1, start of care 10/12/12, included a Home Health</p>	G0337	<p>Director of Nursing/designee will in-service all current nurses on the need to include the strength of the medication on the med sheet. 11/30/12</p> <p>Director of Nursing/designee will include as part of orientation for newly hired nurses that medications listed must also include strength of medication. On-going</p> <p>Director of Nursing/designee will in-service all current nurses on medication interactions must be run at the time of admission and anytime a new medication is added. 11/30/12</p> <p>Director of Nursing/designee will instruct newly hired nurses on the timeframes for when medication interactions must be run as part of their orientation. On-going</p> <p>Director of Nursing/designee will in-service all current nurses on the need to check off and sign Drug Regimen Review whenever making</p>	11/30/2012			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Certification and Plan of Care for the certification period from 10/12/12 to 12/10/12. Review of the clinical record evidenced the following:</p> <p>A. On 11/9/12, employee E, Registered Nurse, listed on the Verbal Order form new orders for Clonidine 0.3 mg [milligram], Lisinopril 40 mg, Hydrocodone APAP 10/500, MS Contin 30 mg, Theragran MVI, and Oscal with Vitamin D 500/1250/200.</p> <p>The Medication Profile form failed to evidence employee E, Registered Nurse, documented the Hydrocodone APAP dosage.</p> <p>B. Review of the Medication Profile form evidenced the last Drug Regimen Review to check for side effects and interactions was completed on 10/12/12 by employee E, Registered Nurse. There was no indication a new Drug Regimen Review was completed after the new medications were added on 11/9/12.</p> <p>C. On 11/16/12 at 6:00 PM, employee E, Registered Nurse, indicated the failure to check off and sign Drug Regimen Review when new medications were added.</p> <p>3. Clinical record #3, start of care</p>		<p>any changes to the medication profile. 11/30/12</p> <p>Director of Nursing/designee will instruct newly hired nurses on the need to check off and sign Drug Regimen Review whenever making any changes to the medication profile. On-going</p>				

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	<p>10/5/12, included a Home Health Certification and Plan of Care for the certification period from 10/5/12 to 12/3/12. Review of the clinical record evidenced the following:</p> <p>A. On 10/11/12, employee E, Registered Nurse, listed on the Verbal Order form a new order for Zofran 4 mg [milligrams]. The Verbal Order form failed to evidence employee E, Registered Nurse, also listed on the Verbal Order form the new orders for Levaquin 500 mg and Flagyl 500 mg for 10/15/12.</p> <p>B Review of the Medication Profile form evidenced the last Drug Regimen Review to check for side effects and interactions was completed on 10/5/12 by employee E, Registered Nurse. There was no indication a new Drug Regimen Review was completed after the new medications were added on 10/11/12 and 10/15/12.</p> <p>C. On 11/16/12 at 6:00 PM, employee E, Registered Nurse, indicated the failure to check off and sign Drug Regimen Review when the new medications were added.</p>						

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N0000	<p>This visit was a Home Health Initial State Licensure survey.</p> <p>Survey Dates: November 15 and 16, 2012</p> <p>Facility Number: 012999</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 10 Home Health Aide Only: 0 Personal Care Only: 0 Total: 10</p> <p>Sample: RR w/HV: 1 RR w/o HV: 9 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 21, 2012</p>	N0000		

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N0454	<p>410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to: (1) respond to an emergency; (2) provide guidance to staff; (3) answer questions; and (4) resolve issues; within a reasonable amount of time, given the emergency or issue that has been raised.</p> <p>Based on policy review, observation, and interview, the agency failed to ensure an administrator or qualified alternate was available at all times during operating hours for 1 of 1 agency reviewed with the potential to effect all 7 active patients of this agency.</p> <p>Findings:</p> <p>1. Facility policy titled "After Hours Care" document number 3.013.1, undated states, "Upon admission, all agency patients will be made aware that normal business hours are 9 a.m.-5 p.m. M-F [Monday through Friday]. After 5:00, the on-call person will take a message and relay the information to the RN on call as needed."</p> <p>2. On 11/15/12 at 9:15 AM, upon arrival</p>	N0454	<p>The Administrator/designee will ensure the office number rolls over to the on-call person after hours and if the office person should have to step away from office. Immediately</p> <p>Administrator/designee will instruct staff that when on-call they need to check for voicemails regularly. Immediately</p> <p>Administrator/designee will instruct staff that when on-call they are to return calls within 30 minutes or less. Immediately</p> <p>On-call policy has been updated by Consultant to add "calls will be returned in 30 minutes or as soon as the person is able to return call." 11/23/12 (See attachment)</p> <p>Director of Nursing/designee will include review of the on-call policy as part of orientation of newly hired</p>	11/23/2012			

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	<p>to facility, the door was locked. The number listed on agency door and provided to the Indiana State Department of Health (ISDH) was (317) 841-0630. The office hours listed on the door was from 9:00 AM to 5:00 PM.</p> <p>On 11/15/12 at 9:23 AM, phone call was placed to reach agency, voicemail prompted, and message left. No call was returned as of 11:15 AM.</p> <p>3. On 11/15/12 at 11:30 AM, employee B, owner, indicated the agency's phone number is on the agency door, and, when calls are made after hours, they are routed to employee's cell phone. Employee further indicated voicemail is checked regularly. Employee could not explain why voicemail that was left at 9:15 AM was not returned</p> <p>4. On 11/15/12 at 12:30 PM, during Entrance Conference, employee E, Registered Nurse, indicated calls are received by employee B, owner, who is then is responsible for routing to responsible personnel. Employee E indicated that someone should always be available to take call for the agency, and calls need to be returned within 10 to 15 minutes.</p>		nurses. On-going				

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N0464	<p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on</p>						

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	<p>a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file review and interview, the agency failed to ensure Tuberculosis (TB) screenings with a two step Mantoux was completed upon hire for 2 of 4 files reviewed of employees with patient contact with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Personnel file D, date of hire 6/26/12 and first patient contact 11/14/12, failed to evidence a negative Mantoux within the previous 12 months and contained only one record of a tuberculosis screening completed on 9/13/12. Personnel file E, date of hire 6/25/12 and first patient contact 9/28/12, failed to evidence a negative Mantoux within the previous 23 months and contained only one record of a tuberculosis 	N0464	<p>Upon hire if clinical person does not have proof of a negative PPD in the past 12 months, the employee will have a two step PPD completed. The Director of Nursing/designee will be responsible to check PPD status of all employees before they are assigned to see patients. On-going</p> <p>The two employees cited during survey will go for another PPD. Director of Nursing/designee will ensure this is completed and copy of results placed in their employee files. 12/7/12</p>	12/07/2012			

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	<p>screening completed on 7/25/12.</p> <p>3. On 11/16/12, at 7:00 PM, employee B, CEO, indicated a second step Mantoux test was not completed for either employee.</p>			

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to provide skilled nursing services and home health aide services in accordance with the plan of care in 5 of 7 active records reviewed with the potential to affect all the agency's patients. (#1, 2, 4, 5, and 7).</p> <p>The findings include:</p> <p>1. Facility policy titled "Nurse Supervision" document number 6.020.1, undated states,"1. The supervising nurse will routinely review the POC and all subsequent orders and review notes to ensure that the POC is directly being followed and all orders have been signed by the physician. The nurse will also notify the office manager if orders have not been received by the physician in order to ensure that the physician orders be obtained and filed within 60 days ... 3. The supervising nurse will ensure that the patients POC is being followed through chart audits, note reviews, staff</p>	N0522	<p>The policy on Nursing Supervision (6.020.1) has been revised by the Consultant to correct who is responsible for tracking MD orders. 11/23/12 (See attachment)</p> <p>Current nursing staff will be in-serviced by Director of Nursing/designee on policy for Nursing Supervision. 11/30/12</p> <p>Director of Nursing/designee will in-service newly hired nurses on the Policy for Nursing Supervision as part of their orientation. On-going</p> <p>Director of Nursing/designee will review 100% of visit documentation to ensure the Plan of Care is being followed until 100% compliance is achieved. On-going</p> <p>Once 100% compliance is achieved, Director of Nursing/designee will audit 10% of documentation weekly to ensure the Plan of Care is being followed. On-going</p> <p>Director of Nursing/designee will include in orientation of newly hired nurses the requirement to follow</p>	11/30/2012			

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	<p>communication and client communication."</p> <p>2. Clinical record #1, start of care 10/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/12/12 to 12/10/12 with orders that state, "Assess Cardiovascular status ... Assess and Instruct s/s [signs and symptoms] of Hypo/Hyperglycemia." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/18/12, employee E, Registered Nurse, failed to assess for hypo/hyperglycemia. The section of the Nursing Assessment titled "Endocrine" was left blank.</p> <p>B. On 10/25/12, employee E, Registered Nurse, failed to assess for cardiovascular status. The section of the Nursing Assessment titled "Chest Pain" was left blank.</p> <p>C. On 11/14/12, employee D, Registered Nurse, failed to assess for hypo / hyperglycemia. The section of the Nursing Assessment titled "Endocrine" was left blank.</p> <p>D. On 11/16/12 at 5:50 PM, employee E,</p>		<p>the Plan of Care and document according to the Plan of Care. On-going</p> <p>Director of Nursing/designee will audit 20% of charts monthly to ensure visit frequency is being followed or there is a missed visit report. On-going</p>				

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	<p>Registered Nurse, indicated these sections were not completed.</p> <p>3. Clinical record #2, start of care 10/01/12, included an order dated 10/18/12 for Home Health Aide (HHA) to begin on 10/18/12 up to 2 hours for 2 days per week. Beginning on 10/22/12, the order states the HHA reports 2 hours per day for 5 days per week. The week of 10/18/12 no HHA visits were made. The week of 10/22/12, only 2 HHA visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p> <p>On 11/16/12 at 6:15 PM, employee E, Registered Nurse, indicated the visits were not in the chart.</p> <p>4. Clinical record #4, start of care 10/3/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/3/12 to 12/1/12 with orders that state, "Assess VS [Vital Signs] ... Assess, Perform, Instruct Fluid intake." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/10/12, 10/16/12, 10/23/12, 10/30/12, 11/6/12, 11/13/12, employee</p>						

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	<p>E, Registered Nurse, failed to assess for fluid intake.</p> <p>B. On 10/30/12, employee E, Registered Nurse, failed to assess all vital signs. Temperature and Respirations were not documented.</p> <p>5. Clinical record #5, start of care 10/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/5/12 to 12/3/12 with orders that state, "Assess VS." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/10/12, employee E, Registered Nurse, failed to assess Temperature.</p> <p>B. On 10/25/12, employee E, Registered Nurse, failed to assess Blood Pressure.</p> <p>6. Clinical record #7, start of care 9/28/12, included a Home Health Certification and Plan of Care for the Certification Period from 9/28/12 to 11/26/12 with orders for Skilled Nursing 1 time per week for 9 weeks. The record failed to evidence all scheduled Skilled Nursing visits were made as ordered. The week of 10/22/12 and 10/29/12 no Skilled Nursing visits were made. There were no missed visit notes or evidence</p>						

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	the doctor was notified of the missed visits in the record.			

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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to provide skilled nursing services in accordance with the plan of care in 4 of 7 active records reviewed with the potential to affect all the agency's patients that receive skilled nurse services. (#1, 4, 5, and 7).</p> <p>The findings include:</p> <p>1. Facility policy titled "Nurse Supervision" document number 6.020.1, undated states,"1. The supervising nurse will routinely review the POC and all subsequent orders and review notes to ensure that the POC is directly being followed and all orders have been signed by the physician. The nurse will also notify the office manager if orders have not been received by the physician in order to ensure that the physician orders be obtained and filed within 60 days ... 3. The supervising nurse will ensure that the patients POC is being followed through chart audits, note reviews, staff</p>	N0537	<p>The policy on Nursing Supervision (6.020.1) has been revised by the Consultant to correct who is responsible for tracking MD orders. 11/23/12 (See attachment)</p> <p>Director of Nursing/designee will track MD orders using a tracking tool. 11/30/12 (See attachment)</p> <p>Director of Nursing/designee will follow MD order tracking policy. 11/30/12 (See attachment)</p> <p>Current nursing staff will be in-serviced by Director of Nursing/designee on policy for Nursing Supervision. 11/30/12</p> <p>Director of Nursing/designee will in-service newly hired nurses on the Policy for Nursing Supervision as part of their orientation. On-going</p> <p>Director of Nursing/designee will review 100% of visit documentation to ensure the Plan of Care is being followed until 100% compliance is achieved. On-going</p> <p>Once 100% compliance is achieved,</p>	11/30/2012			

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NAME OF PROVIDER OR SUPPLIER RELIABLE HOME HEALTHCARE SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 6801 LAKE PLAZA DRIVE, SUITE A107 INDIANAPOLIS, IN 46220			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>communication and client communication."</p> <p>2. Clinical record #1, start of care 10/12/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/12/12 to 12/10/12 with orders that state, "Assess Cardiovascular status ... Assess and Instruct s/s [signs and symptoms] of Hypo/Hyperglycemia." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/18/12, employee E, Registered Nurse, failed to assess for hypo/hyperglycemia. The section of the Nursing Assessment titled "Endocrine" was left blank.</p> <p>B. On 10/25/12, employee E, Registered Nurse, failed to assess for cardiovascular status. The section of the Nursing Assessment titled "Chest Pain" was left blank.</p> <p>C. On 11/14/12, employee D, Registered Nurse, failed to assess for hypo / hyperglycemia. The section of the Nursing Assessment titled "Endocrine" was left blank.</p> <p>D. On 11/16/12 at 5:50 PM, employee E,</p>		<p>Director of Nursing/designee will audit 10% of documentation weekly to ensure the Plan of Care is being followed. On-going</p> <p>Director of Nursing/designee will include in orientation of newly hired nurses the requirement to follow the Plan of Care and document according to the Plan of Care. On-going</p> <p>Director of Nursing/designee will audit 20% of charts monthly to ensure visit frequency is being followed or there is a missed visit report. On-going</p>				

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	<p>Registered Nurse, indicated these sections were not completed.</p> <p>3. Clinical record #4, start of care 10/3/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/3/12 to 12/1/12 with orders that state, "Assess VS [Vital Signs] ... Assess, Perform, Instruct Fluid intake." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/10/12, 10/16/12, 10/23/12, 10/30/12, 11/6/12, 11/13/12, employee E, Registered Nurse, failed to assess for fluid intake.</p> <p>B. On 10/30/12, employee E, Registered Nurse, failed to assess all vital signs. Temperature and Respirations were not documented.</p> <p>4. Clinical record #5, start of care 10/5/12, included a Home Health Certification and Plan of Care for the Certification Period from 10/5/12 to 12/3/12 with orders that state, "Assess VS." Review of the Nursing Visit Notes evidenced the following:</p> <p>A. On 10/10/12, employee E, Registered Nurse, failed to assess Temperature.</p>						

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NAME OF PROVIDER OR SUPPLIER RELIABLE HOME HEALTHCARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 6801 LAKE PLAZA DRIVE, SUITE A107 INDIANAPOLIS, IN 46220
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	<p>B. On 10/25/12, employee E, Registered Nurse, failed to assess Blood Pressure.</p> <p>5. Clinical record #7, start of care 9/28/12, included a Home Health Certification and Plan of Care for the Certification Period from 9/28/12 to 11/26/12 with orders for Skilled Nursing 1 time per week for 9 weeks. The record failed to evidence all scheduled Skilled Nursing visits were made as ordered. The week of 10/22/12 and 10/29/12 no Skilled Nursing visits were made. There were no missed visit notes or evidence the doctor was notified of the missed visits in the record.</p>			