

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
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NAME OF PROVIDER OR SUPPLIER  SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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G000000	<p>This was a revisit for the Federal recertification survey completed on 12-2-13, 12-3-13, 12-4-13, and 12-5-13 that resulted in an extended survey.</p> <p>Survey Date: 1-13-14</p> <p>Facility #: 003248</p> <p>Medicaid Vendor #: 200387670</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Three (3) conditions and 13 standards were found to be corrected as a result of this survey. One (1) condition and 12 standards remain uncorrected and were recited.</p> <p>Sullivan County Community Hospital Home Health is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years starting 1-14-14 due to being found out of compliance with 42 CFR 484.18 Acceptance of Patients, Plans of Care, and Medical Supervision.</p> <p>The Home Health Director and the hospital Clinical Nursing Director were informed of this preclusion during the</p>	G000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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G000121	<p>exit conference held on 1-13-14 at 2:15 PM.</p> <p>Current Census:</p> <p>32 skilled patients 0 home health aide only patients 0 personal service only patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 14, 2014</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on clinical record and agency policy review and interview, the agency failed to ensure the physical therapist examined the patient in accordance with Indiana Administrative Code in 1 (# 34) of 2 records reviewed of patients that received physical therapy services creating the potential to affect all patients that received physical therapy services from the agency.</p> <p>The findings include:</p> <p>1. 844 IAC 6-1-2 (g) states, "The supervising physical therapist of</p>	G000121	G0121: Physical Therapy Evaluations: Policy #900.70 does reflect the need for the therapist to re-evaluate the patient every 30 days or every 15th visit which ever comes first. Every patient chart receiving therapy services has been reviewed for compliance with this standard. PT visits have been scheduled and are to be completed by 1/17/14. A new tracking form has been implemented to assist agency staff to track the dates for re-evaluation in a more efficient manner (Documentation Attached). The HHA Administrator will be responsible for ensuring that compliance is maintained.	01/17/2014

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	<p>physician shall examine each patients not less than: . . . (3) the earlier of every thirty (30) days or every fifteen (15) physical therapy visit for all other patients."</p> <p>2. Clinical record number 34 evidenced the physical therapy assistant (PTA), employee G, had provided services to the patient 3 times per week during the certification period 10-21-13 to 12-19-13 and the physical therapist, employee C, had last examined the patient on 11-29-13. The record evidenced the PTA had continued to provide services 2 times per week during the certification period 12-21-13 to 02-17-14 with no further exam by the physical therapist documented since 11-29-13.</p> <p>3. The PTA, employee G, stated, on 1-14-13 at 1:30 PM, "The physical therapist did not do a re-assessment every 30 days as required."</p> <p>4. The agency's April 2002 "Client Home Health Care Visit Protocol for Rehabilitation Services" policy number 900.70 states, "The supervising physical/occupational therapist or physician shall re-evaluate each client the earlier of every thirty days or every fifteen therapy visits."</p>			

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G000143	<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. Based on clinical record and agency policy review and interview, the agency failed to ensure clinical records or minutes of case conferences established that the agency had maintained communication with other service providers in 2 (#s 5 and 9) of 2 records reviewed of patients that received services from other care providers creating the potential to affect all of the agency's patients that receive services from another provider.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 included a "Case Conference Note" dated 1-8-14 that identified another agency was providing services to the patient in addition to the services provided by this agency. The record failed to evidence any communication and/or coordination of care with the other service provider.</li> <li>2. Clinical record number 9 included an addendum to the plan of care established by the physician for the certification period 12-28-13 to 02-25-14 that</li> </ol>	G000143	G0143: Coordination of Care: Policy #900.98 addresses the need for coordination with other service providers and the requirement for documentation in the patient chart. This policy was reviewed with agency staff. All patient's receiving services from another provider have undergone a chart review, all other providers have been notified and process set up to coordinate services on a regularly scheduled basis. The coordination will be documented in the patient chart communication log. The HHA Administrator will be responsible for ensuring compliance with this standard. (Documentation Attached)	01/17/2014			

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G000144	<p>identifies the patient received hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</p> <p>3. The Home Care Director, employee H, indicated, on 1-13-14 at 11:40 AM, the records did not evidence communication and/or coordination with the other service providers.</p> <p>4. The agency's April 2002 "Coordination of Services/Case Management" policy number 900.98 states, "Coordination of care provided by other organizations serving the patient is done on an ongoing basis. The coordination may be achieved by phone calls or on site conferences and should be documented in the patient's record. All services will be listed on the patient's plan of care (CMS 485)."</p> <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. Based on clinical record and agency policy review and interview, the agency</p>	G000144	G0144: Coordination of Care: Policy #900.98 addresses the need for coordination with other	01/17/2014			

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	<p>failed to ensure clinical records or minutes of case conferences established that the agency had maintained communication with other service providers in 2 (#s 5 and 9) of 2 records reviewed of patients that received services from other care providers creating the potential to affect all of the agency's patients that receive services from another provider.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 included a "Case Conference Note" dated 1-8-14 that identified another agency was providing services to the patient in addition to the services provided by this agency. The record failed to evidence any communication and/or coordination of care with the other service provider.</li> <li>2. Clinical record number 9 included an addendum to the plan of care established by the physician for the certification period 12-28-13 to 02-25-14 that identifies the patient received hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</li> <li>3. The Home Care Director, employee H, indicated, on 1-13-14 at 11:40 AM,</li> </ol>		<p>service providers and the requirement for documentation in the patient chart. This policy was reviewed with agency staff. All patient's receiving services from another provider have undergone a chart review, all other providers have been notified and process set up to coordinate services on a regularly scheduled basis. The coordination will be documented in the patient chart communication log. The HHA Administrator will be responsible for ensuring compliance with this standard. (Documentation Attached)</p>				

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G000145	<p>the records did not evidence communication and/or coordination with the other service providers.</p> <p>4. The agency's April 2002 "Coordination of Services/Case Management" policy number 900.98 states, "Coordination of care provided by other organizations serving the patient is done on an ongoing basis. The coordination may be achieved by phone calls or on site conferences and should be documented in the patient's record. All services will be listed on the patient's plan of care (CMS 485)."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. Based on clinical record review and interview, the agency failed to ensure written summary reports had been sent to the physician at least every sixty (60) days in 2 (#s 9 and 34) of 2 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's patients receiving services longer than 60 days.</p>	G000145	G0145: Written Summary: Education on the appropriate content of a written summary was reviewed with the nurse. All patient charts from this particular nurse will be reviewed for the content of the written summary and one on one education and support will be provided to ensure accuracy. The HHA Administrator will be responsible for reviewing all written summaries prior to being sent to the physician for accuracy and completeness.	01/21/2014			

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	<p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 9, start of care 7-1-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced skilled nursing (SN) services had been provided 1 to 2 times per week during the certification periods 10-29-13 to 12-27-13 and 12-28-13 to 02-25-14.</li> <li>2. Clinical record number 34, start of care 10-21-13, failed to evidence a written summary reports that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced SN, physical therapy, and occupational therapy services had been provided during the certification periods 10-21-13 to 12-19-13 and 12-20-13 to 02-17-14.</li> <li>3. The hospital Chief Nursing Officer, employee K, indicated, on 1-13-14 at 10:35 AM, the records did not include written summary reports that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician.</li> </ol>		(Documentation Attached)				

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G000156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure skilled nursing visits had been provided in accordance with physician orders (See G 158); by failing to ensure plans of care included all services and medications (See G 159); and by failing to ensure orders for therapy services included the specific procedures and modalities to be used and the amount, frequency, and duration of services (See G 161).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out compliance with this condition, 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p>	G000156	G0156: Acceptance of Patients, POC and Med Super: HHA Administrator has reviewed the chart(s) involved. The appropriate corrections and updates have been completed and are attached. Reminded staff of clinical education provided on updating a plan of care and the requirements for a Plan of Care. The HHA Administrator will be responsible for monitoring compliance thru chart audits. (Documentation Attached)	01/20/2014			
G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure visits had been provided as ordered by the physician in 1 (# 5) of</p>	G000158	G0158: Missed Visits: The HHA Administrator will educate staff on the appropriate way to handle missed visits and the need to document the offering of an	01/20/2014			

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	<p>3 records reviewed creating the potential to affect all of the agency's 32 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 included a verbal order dated 12-13-13 that identified skilled nursing visits were to be increased to 1 time per week through the certification period. The record failed to evidence any skilled nursing visits had been provided the week of 12-29-13.</li> <li>2. The Home Care Director, employee H, indicated, on 1-13-14 at 1:50 PM, the record did not evidence any skilled nursing visits the week of 12-29-13.</li> <li>3. The agency's April 2002 "Plan of Care" policy number 900.86 states, "A plan of care is developed by the physician, case manager, and interdisciplinary team members; care provided to that patient is in accordance with the plan of care and any additions or modifications must be approved by the physician."</li> </ol>		<p>additional visit when the patient is cancelling the scheduled visit. Patient visit tracking process has been improved and is being conducted daily to identify any area of concern. The HHA Administrator will be responsible for ensuring patient visits are conducted as ordered and/or appropriately written orders are present explaining a missed visit. (Documentation Attached)</p>		

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G000159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all services required and all medications in 2 (#s 5 and 9) of 3 records reviewed creating the potential to affect all of the agency's 32 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a plan of care established by the physician for the certification period 11-18-13 to 01-16-14. The record failed to evidence the plan of care had been updated to include home health services being provided to the patient by another home health agency.</p> <p>A. The record included a "Care Plan Update/Case Conference Note" dated 1-8-14 that identified the patient received services from another provider</p>	G000159	G0159: Coordination of Care: Policy #900.98 addresses the need for coordination with other service providers and the requirement for documentation in the patient chart. This policy was reviewed with agency staff. All patient's receiving services from another provider have undergone a chart review, all other providers have been notified and process set up to coordinate services on a regularly scheduled basis. The coordination will be documented in the patient chart communication log. The HHA Administrator will be responsible for ensuring compliance with this standard. Medication Record: The HHA Administrator will educate the clinical on the appropriate process for ensuring all medications are identified and present on the patients record. The education will consist of what is required to be on the MAR, the process for adding a medication to the MAR and the process for removing a medication from the	01/20/2014	

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	<p>and identified the payer source. The update failed to evidence what the services were or the frequency of the services being provided.</p> <p>B. The registered nurse, employee B, stated, on 1-13-14 at 9:50 AM, "I did not specify what the services were [the other agency was providing]. It is a home health aide."</p> <p>2. Clinical record number 9 included an addendum to the plan of care established by the physician for the certification period 12-28-13 to 2-25-14 that identified the patient received hemodialysis treatments 3 times per week. The plan of care failed to include medications administered to the patient during the dialysis treatment.</p> <p>The Home Care Director, employee H, indicated, on 1-13-14 at 11:40 AM, she had telephoned the dialysis facility and that a staff member had confirmed medications were administered to the patient during the dialysis treatment.</p> <p>3. The agency's April 2002 "Plan of Care" policy number 900.86 states, "The plan of care covers all pertinent diagnoses, including . . . types of services and equipment required . . . medications and treatments."</p>		<p>MAR. Education will also include the need for the medication interaction review to be monitored and communicated to the MD when appropriate, as well as printing a new MAR with every change. The HHA Administrator will be responsible for ensuring the MAR's are being updated appropriately through the chart audit process. (Documentation Attached)</p>				

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G000161	<p>484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. Based on clinical record review and interview, the agency failed to ensure orders for therapy services included the specific procedures and modalities to be used and the amount, frequency, and duration of services in 1 (# 34) of 2 records reviewed of patients that received therapy services creating the potential to affect all patients that receive therapy services.</p> <p>The findings include:</p> <p>1. Clinical record number 34 included a verbal order dated 12-18-13 that states, "Recertification of home health services . . . PT [physical therapy]/OT [occupational therapy] to continue to treat patient with their current plan of care." The plan of care established by the physician for the certification period 12-20-13 to 2-17-14 states, "Therapy Need and Plan of Care: Physical Therapy Evaluation Occupational Therapy Evaluation." The plan of care failed to evidence specific procedures and modalities to be used and failed to</p>	G000161	<p>G0161: The HHA Administrator will educate clinical on the need to specify the therapy services provided to the patient on the recertification which includes frequency and modalities. The past practice of writing "conitnue current plan of care" for therapy service patients will be immediately ceased and appropriate orders will be obtained upon recertification.The HHA Administrator will be responsible for ensuring the correctness of orders through the chart audit process. (Documentation Attached)</p>	01/20/2014
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G000170	<p>include amount, frequency, and duration of the therapy services.</p> <p>2. The Home Care Director, employee H, indicated, on 1-13-14 at 1:30 PM, the plan of care did not include the specific procedures and modalities to be used or the amount, frequency, and duration of the therapy services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing visits had been provided as ordered by the physician in 1 (# 5) of 3 records reviewed creating the potential to affect all of the agency's 32 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a verbal order dated 12-13-13 that identified skilled nursing visits were to be increased to 1 time per week through the certification period. The record failed to evidence any skilled nursing visits had been provided the week of 12-29-13.</p>	G000170	G0170: Missed Visits: The HHA Administrator will educate staff on the appropriate way to handle missed visits and the need to document the offering of an additional visit when the patient is cancelling the scheduled visit. Patient visit tracking process has been improved and is being conducted daily to identify any area of concern. The HHA Administrator will be responsible for ensuring patient visits are conducted as ordered and/or appropriately written orders are present explaining a missed visit. (Documentation Attached)	01/17/2014			

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G000176	<p>2. The Home Care Director, employee H, indicated, on 1-13-14 at 1:50 PM, the record did not evidence any skilled nursing visits the week of 12-29-13.</p> <p>3. The agency's April 2002 "Plan of Care" policy number 900.86 states, "A plan of care is developed by the physician, case manager, and interdisciplinary team members; care provided to that patient is in accordance with the plan of care and any additions or modifications must be approved by the physician."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had coordinated care with other service providers in 2 (#s 5 and 9) of 2 records reviewed of patients that received services from other care providers creating the potential to affect all of the agency's patients that receive services from another provider.</p> <p>The findings include:</p>	G000176	G0176: Coordination of Care: Policy #900.98 addresses the need for coordination with other service providers and the requirement for documentation in the patient chart. This policy was reviewed with agency staff. All patient's receiving services from another provider have undergone a chart review, all other providers have been notified and process set up to coordinate services on a regularly scheduled basis. The coordination will be documented	01/17/2014

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	<p>1. Clinical record number 5 included a "Case Conference Note" dated 1-8-14 that identified another agency was providing services to the patient in addition to the services provided by this agency. The record failed to evidence any communication and/or coordination of care with the other service provider.</p> <p>2. Clinical record number 9 included an addendum to the plan of care established by the physician for the certification period 12-28-13 to 02-25-14 that identifies the patient received hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</p> <p>3. The Home Care Director, employee H, indicated, on 1-13-14 at 11:40 AM, the records did not evidence communication and/or coordination with the other service providers.</p> <p>4. The agency's April 2002 "Clinical Staff Functions" policy number 900.25 states, "Professional nursing services is provided by a registered nurse . . . Skilled nursing services may include, but are not limited to: . . . Coordinating services with other disciplines and facilities, as indicated."</p>		in the patient chart communication log. The HHA Administrator will be responsible for ensuring compliance with this standard. (Documentation Attached)				

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G000236	<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 and interview, the agency failed to ensure clinical records included written summary reports sent to the physician at least every sixty (60) days in 2 (#s 9 and 34) of 2 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's patients receiving services longer than 60 days.</p> <p>The findings include:</p> <p>1. Clinical record number 9, start of care 7-1-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes had been sent</p>	G000236	G0236: Written Summary: Education on the appropriate content of a written summary was reviewed with the nurse. All patient charts from this particular nurse will be reviewed for the content of the written summary and one on one education and support will be provided to ensure accuracy. The HHA Administrator will be responsible for reviewing all written summaries prior to being sent to the physician for accuracy and completeness. (Documentation Attached)	01/17/2014	

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	<p>to the physician. The record evidenced skilled nursing (SN) services had been provided 1 to 2 times per week during the certification periods 10-29-13 to 12-27-13 and 12-28-13 to 02-25-14.</p> <p>2. Clinical record number 34, start of care 10-21-13, failed to evidence a written summary reports that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced SN, physical therapy, and occupational therapy services had been provided during the certification periods 10-21-13 to 12-19-13 and 12-20-13 to 02-17-14.</p> <p>3. The hospital Chief Nursing Officer, employee K, indicated, on 1-13-14 at 10:35 AM, the records did not include written summary reports that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician.</p>				

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G000335	<p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record and agency policy review and interview, the agency failed to ensure comprehensive assessments were complete and accurately reflected the patient's status in 1 (# 9) of 3 records reviewed creating the potential to affect all of the agency's 32 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 9 included an addendum to the plan of care established by the physician for the certification period 12-28-13 to 2-25-14 that identified the patient received hemodialysis treatments 3 times per week.</li> </ol> <p>The record included a recertification comprehensive assessment completed by the registered nurse, employee B, on 12-27-13. The assessment failed to include an assessment of the patient's condition related to the dialysis.</p> <ol style="list-style-type: none"> <li>The Home Care Director, employee</li> </ol>	G000335	G0335: Comprehensive Assessment: The HHA Administrator has reinitiated clinical education with registered nurse, employee B. The Recertification Comprehensive Assessment was reviewed and updated prior to submission to reflect the assessment of the patient as related to dialysis. The RN's documentation will be reviewed from each encounter and assessed for appropriateness and completeness. The HHA Administrator will be responsible for reviewing the documentation daily. (Documentation Attached)	01/20/2014			

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G000337	<p>H, indicated, on 1-13-14 at 11:40 AM, the assessment dated 12-27-13 did not evidence an assessment of the patient's condition related to the dialysis</p> <p>3. The agency's April 2002 "Initial and Comprehensive Assessment" policy number 900.75 states, "A registered nurse will conduct and complete the comprehensive assessment."</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify 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. Based on clinical record and agency policy review and interview, the agency failed to ensure comprehensive assessments included a review of all medications in 1 (# 9) of 3 records reviewed creating the potential to affect all of the agency's 32 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 9 included a recertification comprehensive assessment dated 12-27-13. The medication review failed to include</p>	G000337	G0337: .Medication Record: The HHA Administrator will educate the clinical on the appropriate process for ensuring all medications are identified and present on the patients record. The education will consist of what is required to be on the MAR, the process for adding a medication to the MAR and the process for removing a medication from the MAR. Education will also include the need for the medication interaction review to be monitored and communicated to the MD when appropriate, as well as printing a new MAR with every	01/20/2014

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N000000	<p>medications the patient received during incenter hemodialysis treatments.</p> <p>2. The Home Care Director, employee H, indicated, on 1-13-14 at 11:40 AM, she had telephoned the dialysis facility and that a staff member had confirmed medications were administered to the patient during the dialysis treatment. The director indicated the medications had not been included in a review as a part of the recertification comprehensive assessment.</p> <p>3. The agency's February 2010 "Drug Regimen Review" policy number 900.72 states, "A drug regimen review will be conducted at admission, recertification, resumption with med changes, and as needed on prescription and over the counter medications administered by any route."</p> <p>This was a revisit for the State re-licensure survey completed on 12-2-13, 12-3-13, 12-4-13, and 12-5-13.</p> <p>Survey Date: 1-13-14</p>	N000000	change. The HHA Administrator will be responsible for ensuring the MAR's are being updated appropriately through the chart audit process. (Documentation Attached)		

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N000486	<p>Facility #: 003248</p> <p>Medicaid Vendor #: 200387670</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Fourteen (14) deficiencies were found to be corrected as a result of this survey. Seven (7) deficiencies remain uncorrected and were recited.</p> <p>Current Census:</p> <p>32 skilled patients 0 home health aide only patients 0 personal service only patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 14, 2014</p> <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 and agency policy review and interview, the agency failed to ensure clinical records or minutes of case conferences established that the agency had maintained communication with other service providers in 2 (#s 5 and 9) of 2 records reviewed of patients that received</p>	N000486	N0486: Coordination of Care: Policy #900.98 addresses the need for coordination with other service providers and the requirement for documentation in the patient chart. This policy was reviewed with agency staff. All patient's receiving services from another provider have undergone a chart review, all other providers	01/17/2014			

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	<p>services from other care providers creating the potential to affect all of the agency's patients that receive services from another provider.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 included a "Case Conference Note" dated 1-8-14 that identified another agency was providing services to the patient in addition to the services provided by this agency. The record failed to evidence any communication and/or coordination of care with the other service provider.</li> <li>2. Clinical record number 9 included an addendum to the plan of care established by the physician for the certification period 12-28-13 to 02-25-14 that identifies the patient received hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</li> <li>3. The Home Care Director, employee H, indicated, on 1-13-14 at 11:40 AM, the records did not evidence communication and/or coordination with the other service providers.</li> <li>4. The agency's April 2002 "Coordination of Services/Case</li> </ol>		<p>have been notified and process set up to coordinate services on a regularly scheduled basis. The coordination will be documented in the patient chart communication log. The HHA Administrator will be responsible for ensuring compliance with this standard. (Documentation Attached)</p>				

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N000522	<p>Management" policy number 900.98 states, "Coordination of care provided by other organizations serving the patient is done on an ongoing basis. The coordination may be achieved by phone calls or on site conferences and should be documented in the patient's record. All services will be listed on the patient's plan of care (CMS 485)."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure visits had been provided as ordered by the physician in 1 (# 5) of 3 records reviewed creating the potential to affect all of the agency's 32 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a verbal order dated 12-13-13 that identified skilled nursing visits were to be increased to 1 time per week through the certification period. The record failed to evidence any skilled nursing</p>	N000522	N0522: Missed Visits: The HHA Administrator will educate staff on the appropriate way to handle missed visits and the need to document the offering of an additional visit when the patient is cancelling the scheduled visit. Patient visit tracking process has been improved and is being conducted daily to identify any area of concern. The HHA Administrator will be responsible for ensuring patient visits are conducted as ordered and/or appropriately written orders are present explaining a missed visit. (Documentation Attached)	01/17/2014

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	<p>visits had been provided the week of 12-29-13.</p> <p>2. The Home Care Director, employee H, indicated, on 1-13-14 at 1:50 PM, the record did not evidence any skilled nursing visits the week of 12-29-13.</p> <p>3. The agency's April 2002 "Plan of Care" policy number 900.86 states, "A plan of care is developed by the physician, case manager, and interdisciplinary team members; care provided to that patient is in accordance with the plan of care and any additions or modifications must be approved by the physician."</p>			

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all services required, all medications, and specific therapy orders in 3 (#s 5, 9, and 34) of 3 records reviewed creating the potential to affect all of the agency's current patients that receive therapy services.</p> <p>The findings include:</p>	N000524	N0524: Coordination of Care: Policy #900.98 addresses the need for coordination with other service providers and the requirement for documentation in the patient chart. This policy was reviewed with agency staff. All patient's receiving services from another provider have undergone a chart review, all other providers have been notified and process set up to coordinate services on a regularly scheduled basis. The coordination will be documented in the patient chart	01/20/2014			

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	<p>1. Clinical record number 5 included a plan of care established by the physician for the certification period 11-18-13 to 01-16-14. The record failed to evidence the plan of care had been updated to include home health services being provided to the patient by another home health agency.</p> <p>A. The record included a "Care Plan Update/Case Conference Note" dated 1-8-14 that identified the patient received services from another provider and identified the payer source. The update failed to evidence what the services were or the frequency of the services being provided.</p> <p>B. The registered nurse, employee B, stated, on 1-13-14 at 9:50 AM, "I did not specify what the services were [the other agency was providing]. It is a home health aide."</p> <p>2. Clinical record number 9 included an addendum to the plan of care established by the physician for the certification period 12-28-13 to 2-25-14 that identified the patient received hemodialysis treatments 3 times per week. The plan of care failed to include medications administered to the patient during the dialysis treatment.</p>		<p>communication log. The HHA Administrator will be responsible for ensuring compliance with this standard. (Documentation Attached): Acceptance of Patients, POC and Med Super: HHA Administrator has reviewed the chart(s) involved. The appropriate corrections and updates have been completed and are attached. Reminded staff of clinical education provided on updating a plan of care and the requirements for a Plan of Care. The HHA Administrator will be responsible for monitoring compliance thru chart audits. (Documentation Attached)</p>		

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	<p>The Home Care Director, employee H, indicated, on 1-13-14 at 11:40 AM, she had telephoned the dialysis facility and that a staff member had confirmed medications were administered to the patient during the dialysis treatment.</p> <p>3. Clinical record number 34 included a verbal order dated 12-18-13 that states, "Recertification of home health services . . . PT [physical therapy]/OT [occupational therapy] to continue to treat patient with their current plan of care." The plan of care established by the physician for the certification period 12-20-13 to 2-17-14 states, "Therapy Need and Plan of Care: Physical Therapy Evaluation Occupational Therapy Evaluation."</p> <p>A. The plan of care failed to evidence specific procedures and modalities to be used and failed to include amount, frequency, and duration of the therapy services.</p> <p>B. The Home Care Director, employee H, indicated, on 1-13-14 at 1:30 PM, the plan of care did not include the specific procedures and modalities to be used or the amount, frequency, and duration of the therapy services.</p>						

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N000529	<p>4. The agency's April 2002 "Plan of Care" policy number 900.86 states, "The plan of care covers all pertinent diagnoses, including . . . types of services and equipment required . . . medications and treatments."</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on clinical record review and interview, the agency failed to ensure written summary reports had been sent to the physician at least every 2 months in 2 (#s 9 and 34) of 2 records reviewed of patients that had been on service for longer than 2 months creating the potential to affect all of the agency's patients receiving services longer than 2 months.</p> <p>The findings include:</p> <p>1. Clinical record number 9, start of care 7-1-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced</p>	N000529	N0529: Written Summary: Education on the appropriate content of a written summary was reviewed with the nurse. All patient charts from this particular nurse will be reviewed for the content of the written summary and one on one education and support will be provided to ensure accuracy. The HHA Administrator will be responsible for reviewing all written summaries prior to being sent to the physician for accuracy and completeness. (Documentation Attached)	01/21/2014

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N000537	<p>skilled nursing (SN) services had been provided 1 to 2 times per week during the certification periods 10-29-13 to 12-27-13 and 12-28-13 to 02-25-14.</p> <p>2. Clinical record number 34, start of care 10-21-13, failed to evidence a written summary reports that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced SN, physical therapy, and occupational therapy services had been provided during the certification periods 10-21-13 to 12-19-13 and 12-20-13 to 02-17-14.</p> <p>3. The hospital Chief Nursing Officer, employee K, indicated, on 1-13-14 at 10:35 AM, the records did not include written summary reports that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician.</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency</p>	N000537	N0537: Missed Visits: The HHA	01/20/2014			

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	<p>policy review and interview, the agency failed to ensure skilled nursing visits had been provided as ordered by the physician in 1 (# 5) of 3 records reviewed creating the potential to affect all of the agency's 32 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 included a verbal order dated 12-13-13 that identified skilled nursing visits were to be increased to 1 time per week through the certification period. The record failed to evidence any skilled nursing visits had been provided the week of 12-29-13.</li> <li>2. The Home Care Director, employee H, indicated, on 1-13-14 at 1:50 PM, the record did not evidence any skilled nursing visits the week of 12-29-13.</li> <li>3. The agency's April 2002 "Plan of Care" policy number 900.86 states, "A plan of care is developed by the physician, case manager, and interdisciplinary team members; care provided to that patient is in accordance with the plan of care and any additions or modifications must be approved by the physician."</li> </ol>		<p>Administrator will educate staff on the appropriate way to handle missed visits and the need to document the offering of an additional visit when the patient is cancelling the scheduled visit. Patient visit tracking process has been improved and is being conducted daily to identify any area of concern. The HHA Administrator will be responsible for ensuring patient visits are conducted as ordered and/or appropriately written orders are present explaining a missed visit. (Documentation Attached)</p>				

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N000545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had coordinated care with other service providers in 2 (#s 5 and 9) of 2 records reviewed of patients that received services from other care providers creating the potential to affect all of the agency's patients that receive services from another provider.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 included a "Case Conference Note" dated 1-8-14 that identified another agency was providing services to the patient in addition to the services provided by this agency. The record failed to evidence any communication and/or coordination of care with the other service provider.</li> <li>2. Clinical record number 9 included an addendum to the plan of care established by the physician for the certification period 12-28-13 to 02-25-14 that identifies the patient received</li> </ol>	N000545	N0545: Coordination of Care: Policy #900.98 addresses the need for coordination with other service providers and the requirement for documentation in the patient chart. This policy was reviewed with agency staff. All patient's receiving services from another provider have undergone a chart review, all other providers have been notified and process set up to coordinate services on a regularly scheduled basis. The coordination will be documented in the patient chart communication log. The HHA Administrator will be responsible for ensuring compliance with this standard. (Documentation Attached)	01/17/2014			

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	<p>hemodialysis treatments 3 times per week. The record failed to evidence any communication and/or coordination of care with the dialysis facility.</p> <p>3. The Home Care Director, employee H, indicated, on 1-13-14 at 11:40 AM, the records did not evidence communication and/or coordination with the other service providers.</p> <p>4. The agency's April 2002 "Clinical Staff Functions" policy number 900.25 states, "Professional nursing services is provided by a registered nurse . . . Skilled nursing services may include, but are not limited to: . . . Coordinating services with other disciplines and facilities, as indicated."</p>			

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N000608	<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 and interview, the agency failed to ensure clinical records included written summary reports in 2 (#s 9 and 34) of 2 records reviewed of patients that had been on service for longer than 2 months creating the potential to affect all of the agency's patients receiving services longer than 2 months.</p> <p>The findings include:</p> <p>1. Clinical record number 9, start of care 7-1-13, failed to evidence a written summary report that included a compilation of the pertinent factors of</p>	N000608	N0608: Written Summary: Education on the appropriate content of a written summary was reviewed with the nurse. All patient charts from this particular nurse will be reviewed for the content of the written summary and one on one education and support will be provided to ensure accuracy. The HHA Administrator will be responsible for reviewing all written summaries prior to being sent to the physician for accuracy and completeness. (Documentation Attached)	01/21/2014	

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	<p>clinical and progress notes had been sent to the physician. The record evidenced skilled nursing (SN) services had been provided 1 to 2 times per week during the certification periods 10-29-13 to 12-27-13 and 12-28-13 to 02-25-14.</p> <p>2. Clinical record number 34, start of care 10-21-13, failed to evidence a written summary reports that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced SN, physical therapy, and occupational therapy services had been provided during the certification periods 10-21-13 to 12-19-13 and 12-20-13 to 02-17-14.</p> <p>3. The hospital Chief Nursing Officer, employee K, indicated, on 1-13-14 at 10:35 AM, the records did not include written summary reports that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician.</p>			