

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/28/2014
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NAME OF PROVIDER OR SUPPLIER WABASH-MIAMI HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 ASH ST STE B PO BOX 548 WABASH, IN 46992
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G000000	<p>This was a home health federal re-certification survey. This survey was partial extended.</p> <p>Survey dates: January 23, 24, 27, and 28, 2014</p> <p>Facility: #005275</p> <p>Medicaid Vendor: 100272950A</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Census (unduplicated last 12 months): 261 Skilled: 215 Aide only: 18 Personal service only: 28 Home Visits: 5 Clinical Record Reviews: 13</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 30, 2014</p>	G000000		

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

TITLE

(X6) DATE

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

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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 review, observation, and interview, the agency failed to ensure the plan of care included all the patient's equipment in 3 of 5 home visit observations with the potential to affect all the agency's patients. (#2, 4, and 5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2, start of care 5/2/12, included a plan of care for the certification period of 12/23/13 to 2/20/14 which states, "14. DME and Supplies. Wheelchair, Walker, O2." During a home visit on 1/24/14 at 11:15 AM, it was observed that patient #2 had a shower chair. 2. Clinical record #4, start of care 2/9/10, included a plan of care for the certification period of 1/19/14 to 3/19/14 	G000159	<p>The Administrator will be responsible for educating all nurses and therapists on asking the patient about what DME and supplies they are using in their home. The nurses and therapists will be instructed to update the patient's plan of care and care plan to reflect the equipment and supplies the patient is actually using in the home, as well as any other changes to the care plan that has changed since the last visit. The patients identified as being out of compliance have had their care plans and plans of care updated to reflect what equipment and supplies they are actually using during that certification period. Education to the nurses and therapists will be completed on 2/26/14. When each chart is audited after admission or recertification, it will be added to audit sheet that nurses and therapists confirmed the equipment and supplies each patient is using in the home.</p>	02/26/2014			

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	<p>which states, "14. DME and Supplies. N/A." During a home visit on 1/24/14 at 8 AM, patient #4 was observed to have a cane, walker, and shower chair. Patient indicated, during the home visit, never using the walker and it was given to he/she by a friend just in case it was ever needed.</p> <p>3. Clinical record #5, start of care 9/9/13, included a plan of care for the certification period of 1/7/14 to 3/7/14 which states, "14. DME and Supplies. foam, kling, tape, w/c." During a home visit on 1/24/14 at 12 PM, patient #5 was observed to have a hospital bed and a gait belt used to assist with transfers and ambulation.</p> <p>4. On 1/28/14 at 11:50 AM, employee B (alternate administrator) indicated being unaware the plans of care for patients 2, 4, and 5 did not include all the patient's medical equipment and agrees it should be listed.</p>				

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G000163	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the home health aide care plan was reviewed by the registered nurse at least every 60 days in 1 of 2 records reviewed of patients receiving home health aide services creating the potential to affect all the patients' of the agency receiving home health aide services. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4 evidenced a start of care date as 2/9/10 and a physicians plan of care for certification period 1/19/14 to 3/19/14 which states, "21. Orders for Discipline and Treatments ... Home health aide requested ... 1 hr</p>	G000163	It is the responsibility of the Administrator to ensure that all nurses and therapists are educated on the following. The nurses and therapists will be educated to update care plan every 60 days or sooner if patient has a significant change in condition changing the case mix assignment, transfers and a resumption of care is completed, or is discharged. They will be educated to print a new care plan to be placed in the patient's home folder for the patient, caregiver, and all home care staff to review at each care visit to ensure it is up-to-date and reflects the care the patient is to receive. This task has been added to our recertification/resumption of care audit tool to ensure that a new care plan has been reviewed, printed, and taken to the patient's home every 60 days	02/26/2014	

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N000000	<p>[hour] each visit 3 xwk [times per week] ... AIDE 01-19-14 2-3 x [times]week x 9 weeks." The record evidenced an aide care plan prepared by the registered nurse dated 10/25/13.</p> <p>On 1/28/14 at 11:55 AM, employee B (alternate administrator) indicated the last review of the aide care plan was 10/25/13.</p> <p>2. The agency policy with a revision date of 5/2010 titled "Care Plans" states, "Policy Care plans Policy: a. There shall be a care plan which reflects goals and interventions for each discipline seeing a patient. ... b. Nursing ... 4. Care plans are to be reviewed by the RN [registered nurse] / therapist at least every sixty (60) days, or more frequently if there is a significant change in condition, transfer, or discharge. ... d. Aide Care plans 1. Aide care plans shall be instituted by the RN/therapist responsible for the patient's care."</p> <p>This was a home health state relicensure survey.</p>	N000000	or when a change is noted. All nurses and therapists will be educated in this process by 2/26/14. The patient chart that were found to be out of compliance has been reviewed and updated by the nurse and a copy placed in patient home folder.	

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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 review, observation, and interview, the agency failed to ensure the plan of care included all the patient's equipment in 3 of 5 home visit observations with the potential to affect all the agency's patients. (#2, 4, and 5)</p> <p>Findings include:</p>	N000524	The Administrator will be responsible for educating all nurses and therapists on asking the patient about what DME and supplies they are using in their home. The nurses and therapists will be instructed to update the patient's plan of care and care plan to reflect the equipment and supplies the patient is actually using in the home, as well as any other changes to the care plan that has changed since the last visit. The patients identified as being out of	02/26/2014			

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N000526	<p>patients 2, 4, and 5 did not include all the patient's medical equipment and agrees it should be listed.</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist, and home health agency personnel as often as the severity of the patient's condition requires, but at least once every two (2) months.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the home health aide care plan was reviewed by the registered nurse at least every 60 days in 1 of 2 records reviewed of patients receiving home health aide services creating the potential to affect all the patients' of the agency receiving home health aide services. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4 evidenced a start of care date as 2/9/10 and a physicians plan of care for certification period 1/19/14 to 3/19/14 which states, "21. Orders for Discipline and Treatments ... Home health aide requested ... 1 hr [hour] each visit 3 xwk [times per week] ... AIDE 01-19-14 2-3 x [times]week x 9 weeks." The record evidenced an aide care plan prepared by the registered nurse dated 10/25/13.</p>	N000526	<p>It is the responsibility of the Administrator to ensure that all nurses and therapists are educated on the following. The nurses and therapists will be educated to update care plan every 60 days or sooner if patient has a significant change in condition changing the case mix assignment, transfers and a resumption of care is completed, or is discharged. They will be educated to print a new care plan to be placed in the patient's home folder for the patient, caregiver, and all home care staff to review at each care visit to ensure it is up-to-date and reflects the care the patient is to receive. This task has been added to our recertification/resumption of care audit tool to ensure that a new care plan has been reviewed, printed, and taken to the patient's home every 60 days or when a change is noted. All nurses and therapists will be educated in this process by 2/26/14. The patient chart that</p>	02/26/2014			

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