

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 10/04/2012
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NAME OF PROVIDER OR SUPPLIER INTEGRITY HOME CARE PLUS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5508 E 16TH STREET, SUITE C13 INDIANAPOLIS, IN 46218
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G0000	<p>This visit was for a home health initial medicaid certification. This was a partial extended survey.</p> <p>Survey dates: 10/2-10/4/12</p> <p>Facility # 012827</p> <p>Survey Team:</p> <p>Dawn Snider, RN, PHNS</p> <p>Census Service Type:</p> <p>Skilled Patients: 7 Home Health Aide Only Patients: 1 Personal Service/Hmk: 0 Total: 8</p> <p>Sample:</p> <p>RR w/HV: 4 (SN and HHA were observed on 1 HV) RR w/o HV: 4</p> <p>Total: 8</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 12, 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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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 clinical record review, policy review, and interview, the agency failed to ensure visits were provided as ordered for 1 of 7 active records reviewed with a written plan of care (#7) and the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #7, start of care 7/12/12, included a plan of care for the certification period 7/12/12 to 9/9/12 with orders for skilled nurse visits 2 times a week for 9 weeks. The record failed to evidence a second skilled nurse visit was made the weeks of 8/5/12, 8/12/12, 8/19/12, and 8/26/12.</p> <p>The clinical record also included a plan of care for the certification period 9/5/12 to 11/3/12 with orders for skilled nurse every 2 weeks. The record failed to evidence a skilled nurse visit was made every other week for the weeks of 9/2/12 and 9/16/12.</p> <p>2. On 10/4/12 at 2:20 PM, the</p>	G0158	<p>G 158 Director of Nursing/designee will audit 100% of all charts weekly to ensure there is documentation for ordered frequency for each discipline. Once 100% compliance is achieved, Director of Nursing/designee will audit 10% of charts weekly to ensure compliance is maintained.</p> <p>On-going Director of Nursing/designee will compare 100% of visit notes with the MD orders to ensure appropriate frequency is being followed by that discipline. Once 100% compliance is achieved, Director of Nursing/designee will audit 10% of visit documentation each month for each discipline to ensure compliance is maintained. On-going Director of Nursing/designee will in-service current employees on the importance of following the MD ordered frequency for their discipline. Complete by 11/2/12 Director of Nursing/designee will include in orientation of all new clinical staff the importance of following MD ordered frequency for their discipline. On-going Director of Nursing/designee will in-service current staff on agency policy that visit documentation</p>	11/02/2012			

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	<p>administrator / director of clinical services indicated she made the skilled nurse visits as ordered on the plans of care. She indicated the skilled nurse notes must have been misfiled and she could not locate the missing documentation.</p> <p>3. The undated policy #11010 titled "MAINTENANCE AND RETENTION OF CLINICAL RECORDS" states, "All clinical notes, along with the patient verification of the visit, are to be completed and submitted to the office within 72 hours following completion of the visit. ... Ensuring that the content of the records are filed accurately, i.e., in the correct patient's file, and in a timely manner to ensure currency {sic} of the record."</p> <p>4. The policy #11001 dated 2/29/12 titled "MEDICAL RECORD CONTENT POLICY" states, "All entries in the medical record shall be dated, timed and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided. Additionally, the time and date of each entry (orders, reports, notes, etc.) must be accurately documented."</p>		<p>must be turned into office within 72 hours of the visit. Complete by 11/2/12 Director of Nursing/designee will include in orientation of all new agency staff that visit documentation must be turned in to the office within 72 hours of the visit. On-going Director of Nursing will audit 10% of active charts weekly to ensure documentation is present in patient chart for ordered visit frequency. On-going</p>				

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G0159	<p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the certification period on the plan of care was 60 days in length on 5 of 8 records (#1, 3, 6, 7, and 8) reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care 8/10/12, included a plan of care for the certification period 8/10/12 to 10/4/12, a period of 56 days. 2. Clinical record #3, start of care 7/19/12, included plans of care for the certification periods 7/19/12 to 9/12/12, a period of 56 days, and 9/12/12 to 11/10/12. 3. Clinical record #6, start of care 8/9/12, 	G0159	G 159 Director of Nursing/designee will in-service current nursing staff on how to calculate the 60 day certification period. Complete by 11/2/12 Director of Nursing/designee will include in orientation of new nurses how to calculate the 60 day certification period. On-going Director of Nursing/designee will review all Plans of Care, before being sent to the MD for signature, to ensure the certification dates are for 60 days. Once 100% compliance is achieved, Director of Nursing/designee will audit 20% of Plans of Care monthly to ensure compliance is maintained. On-going Director of Nursing/designee will in-service current nursing staff on policy regarding timeframe for nursing assessments. Complete by 11/2/12 Director of Nursing/designee will include in orientation of new nurses the policy for timeframes of nursing assessments. On-going Director	11/02/2012			

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	<p>included a plan of care for the certification period 8/9/12 to 10/8/12, a period of 61 days.</p> <p>4. Clinical record #7, start of care 7/12/12, included plans of care for the certification periods 7/12/12 to 9/9/12 and 9/5/12 to 11/3/12. The second plan of care should have been dated 9/10/12 to 11/8/12.</p> <p>5. Clinical record #8, start of care 8/8/12, included a plan of care for the certification period of 8/8/12 to 10/2/12, a period of 56 days.</p> <p>6. The policy #10008 dated 3/3/12 titled "ASSESSMENT - NURSING" states, "In conformance with the HHA policy, applicable state and federal laws and regulations and accrediting organization standards as often as the patient's needs require, but no less often than: every 60 days from the start of care."</p>		<p>of Nursing/designee will audit 100% of nursing assessments to ensure they are being done at least every 60 days. Once 100% compliance is achieved, Director of Nursing/designee will audit 20% of documentation monthly to ensure compliance is maintained. On-going A tracking sheet will be implemented by the Director of Nursing/designee to ensure nursing assessments are done at least every 60 days. Complete by 11/2/12 Director of Nursing/designee will in-service current nurses on how to utilize tracking form to ensure nursing assessments are made at least every 60 days. Complete by 11/2/12 Director of Nursing/designee will include in orientation of new nurses how to utilize tracking form to ensure nursing assessments are being done at least every 60 days. On-going</p>				

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G0229	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse completed an on-site supervisory visit of the home health aide in 1 of 1 (#7) records reviewed of patients who received skilled and home health aide services longer than 14 days with the potential to affect all the patients of the agency receiving home health aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #7, start of care 7/12/12, included plans of care for the certification periods 7/12/12 to 9/9/12 and 9/5/12 to 11/3/12 with orders for skilled nurse visits and home health aide 2 times a week for 9 weeks. The record failed to evidence a registered nurse supervisory visit was made the weeks of 9/2/12 and 9/16/12. On 10/4/12 at 2:20 PM, the administrator / director of clinical services indicated she made the supervisory visits, but the notes must be have been misfiled and she could not locate the missing 	G0229	<p>G229</p> <p>Director of Nursing/designee will in-service all nurses on the need to do aide supervisory visits at least every fourteen (14) days when there is an aide involved in a skilled case. On-going</p> <p>A tracking sheet will be implemented by the Director of Nursing/designee to ensure aide supervisory visits are done at least every fourteen (14) days when there is an aide involved in a skilled case. Complete by 11/2/12</p> <p>Director of Nursing/designee will include in orientation of newly hired nurses the regulation regarding supervision visits of aide at least every fourteen (14) days when aide is involved in a skilled case. On-going</p> <p>Director of Nursing/designee will audit 100% of supervisory visits weekly to ensure timeliness of supervisory visits until 100% compliance is achieved. Once 100% compliance is achieved, Director of Nursing/designee will audit 20% of supervisory visit</p>	11/02/2012			

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	documentation. 3. The policy # 10112 dated 2/29/12 titled "RN SUPERVISORY VISITS" states, "A Registered Nurse shall make onsite visits to a patient's home no less frequently than every two (2) weeks [for a supervisory visit] when a patient is receiving skilled nursing care [home health aide and skilled services?]."		notes monthly to ensure compliance is maintained. On-going	

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G0325	<p>484.20(c)(3) TRANSMITTAL OF OASIS DATA The HHA must successfully transmit test data to the State agency or CMS OASIS contractor.</p> <p>Based on interview, and review of agency documents and policy, the agency failed to ensure electronic transmission of Oasis test data was sent to the Indiana Department of Health (ISDH) for 1 of 1 agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence a validation report that identified the agency had test transmitted an Oasis assessment. 2. On 10/4/12 at 6:10 PM, the administrator / director of clinical services indicated an Oasis test transmission had not been sent to ISDH because of a problem with changes in leadership and acquisition of the password. 3. The policy #6013 dated 2/4/2012 titled "REPORTING OASIS INFORMATION" states, "Transmitted data includes the Centers for Medicare and Medicaid Services (CMS) assigned branch identification number, as applicable." 	G0325	G 325 Director of Nursing will enter a test OASIS into HAVEN once the ID/Password has been received. Once ID/Password is received. 12/10/12 Administrator/ Director of Nursing completed a successful transmission of an OASIS.	11/20/2012			

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N0000	<p>This visit was for a home health initial state licensure survey.</p> <p>Survey dates: 10/2-10/4/12</p> <p>Facility # 012827</p> <p>Survey Team:</p> <p>Dawn Snider, RN, PHNS</p> <p>Census Service Type:</p> <p>Skilled Patients: 7 Home Health Aide Only Patients: 1 Personal Service/Hmk: 0 Total: 8</p> <p>Sample:</p> <p>RR w/HV: 4 (SN and HHA were observed on 1 HV) RR w/o HV: 4</p> <p>Total: 8</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 12, 2012</p>	N0000					

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure visits were provided as ordered for 1 of 7 active records reviewed with a written plan of care (#7) and the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #7, start of care 7/12/12, included a plan of care for the certification period 7/12/12 to 9/9/12 with orders for skilled nurse visits 2 times a week for 9 weeks. The record failed to evidence a second skilled nurse visit was made the weeks of 8/5/12, 8/12/12, 8/19/12, and 8/26/12.</p> <p>The clinical record also included a plan of care for the certification period 9/5/12 to 11/3/12 with orders for skilled nurse every 2 weeks. The record failed to evidence a skilled nurse visit was made every other week for the weeks of 9/2/12 and 9/16/12.</p> <p>2. On 10/4/12 at 2:20 PM, the administrator / director of clinical services</p>	N0522	<p>N 0522 Director of Nursing/designee will audit 100% of all charts weekly to ensure there is documentation for ordered frequency for each discipline. Once 100% compliance is achieved, Director of Nursing/designee will audit 10% of charts weekly to ensure compliance is maintained.</p> <p>On-going Director of Nursing/designee will compare 100% of visit notes with the MD orders to ensure appropriate frequency is being followed by that discipline. Once 100% compliance is achieved, Director of Nursing/designee will audit 10% of visit documentation each month for each discipline to ensure compliance is maintained. On-going Director of Nursing/designee will in-service current employees on the importance of following the MD ordered frequency for their discipline. Complete by 11/2/12 Director of Nursing/designee will include in orientation of all new clinical staff the importance of following MD ordered frequency for their discipline. On-going Director of Nursing/designee will in-service current staff on agency policy that visit documentation</p>	11/02/2012			

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	<p>indicated she made the skilled nurse visits as ordered on the plans of care. She indicated the skilled nurse notes must have been misfiled and she could not locate the missing documentation.</p> <p>3. The undated policy #11010 titled "MAINTENANCE AND RETENTION OF CLINICAL RECORDS" states, "All clinical notes, along with the patient verification of the visit, are to be completed and submitted to the office within 72 hours following completion of the visit. ... Ensuring that the content of the records are filed accurately, i.e., in the correct patient's file, and in a timely manner to ensure currency {sic} of the record."</p> <p>4. The policy #11001 dated 2/29/12 titled "MEDICAL RECORD CONTENT POLICY" states, "All entries in the medical record shall be dated, timed and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided. Additionally, the time and date of each entry (orders, reports, notes, etc.) must be accurately documented."</p>		<p>must be turned into office within 72 hours of the visit. Complete by 11/2/12 Director of Nursing/designee will include in orientation of all new agency staff that visit documentation must be turned in to the office within 72 hours of the visit. On-going Director of Nursing will audit 10% of active charts weekly to ensure documentation is present in patient chart for ordered visit frequency. On-going</p>				

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record review, policy review, and interview the agency failed to ensure the care period on the plan of care was 2 months in length on 5 of 8 records reviewed (#1, 3, 6, 7, and 8) with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care</p>	N0524	<p>N 0524 Director of Nursing/designee will in-service current nursing staff on how to calculate the 60 day certification period. Complete by 11/2/12 Director of Nursing/designee will include in orientation of new nurses how to calculate the 60 day certification period. On-going Director of Nursing/designee will review all Plans of Care, before being sent to the MD for signature, to ensure the certification dates are for 60 days. Once 100% compliance is</p>	11/02/2012
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	<p>8/10/12, included a plan of care for the certification period 8/10/12 to 10/4/12, a period of 56 days.</p> <p>2. Clinical record #3, start of care 7/19/12, included plans of care for the certification periods 7/19/12 to 9/12/12, a period of 56 days, and 9/12/12 to 11/10/12.</p> <p>3. Clinical record #6, start of care 8/9/12, included a plan of care for the certification period 8/9/12 to 10/8/12, a period of 61 days.</p> <p>4. Clinical record #7, start of care 7/12/12, included plans of care for the certification periods 7/12/12 to 9/9/12 and 9/5/12 to 11/3/12. The second plan of care should have been dated 9/10/12 to 11/8/12.</p> <p>5. Clinical record #8, start of care 8/8/12, included a plan of care for the certification period of 8/8/12 to 10/2/12, a period of 56 days.</p> <p>6. The policy #10008 dated 3/3/12 titled "ASSESSMENT - NURSING" states, "In conformance with the HHA policy, applicable state and federal laws and regulations and accrediting organization standards as often as the patient's needs require, but no less often than: every 60</p>		<p>achieved, Director of Nursing/designee will audit 20% of Plans of Care monthly to ensure compliance is maintained. On-going Director of Nursing/designee will in-service current nursing staff on policy regarding timeframe for nursing assessments. Complete by 11/2/12 Director of Nursing/designee will include in orientation of new nurses the policy for timeframes of nursing assessments. On-going Director of Nursing/designee will audit 100% of nursing assessments to ensure they are being done at least every 60 days. Once 100% compliance is achieved, Director of Nursing/designee will audit 20% of documentation monthly to ensure compliance is maintained. On-going A tracking sheet will be implemented by the Director of Nursing/designee to ensure nursing assessments are done at least every 60 days. Complete by 11/2/12 Director of Nursing/designee will in-service current nurses on how to utilize tracking form to ensure nursing assessments are made at least every 60 days. Complete by 11/2/12 Director of Nursing/designee will include in orientation of new nurses how to utilize tracking form to ensure nursing assessments are being done at least every 60 days. On-going</p>				

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 10/04/2012
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	days from the start of care."			

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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse completed an on-site supervisory visit of the home health aide in 1 of 1 (#7) records reviewed of patients who received skilled and home health aide services longer than 14 days with the potential to affect all the patients of the agency receiving home health aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #7, start of care 7/12/12, included plans of care for the certification periods 7/12/12 to 9/9/12 and 9/5/12 to 11/3/12 with orders for skilled nurse visits and home health aide 2 times a week for 9 weeks. The record failed to evidence a registered nurse supervisory visit was made the weeks of 9/2/12 and 9/16/12. On 10/4/12 at 2:20 PM, the administrator / director of clinical services 	N0606	<p>N 606 Director of Nursing/designee will in-service all nurses on the need to do aide supervisory visits at least every fourteen (14) days when there is an aide involved in a skilled case. On-going A tracking sheet will be implemented by the Director of Nursing/designee to ensure aide supervisory visits are done at least every fourteen (14) days when there is an aide involved in a skilled case. Complete by 11/2/12 Director of Nursing/designee will include in orientation of newly hired nurses the regulation regarding supervision visits of aide at least every fourteen (14) days when aide is involved in a skilled case. On-going Director of Nursing/designee will audit 100% of supervisory visits weekly to ensure timeliness of supervisory visits until 100% compliance is achieved. Once 100% compliance is achieved, Director of Nursing/designee will audit 20% of supervisory visit notes monthly to ensure compliance is maintained. On-going</p>	11/02/2012			

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	<p>indicated she made the supervisory visits, but the notes must be have been misfiled and she could not locate the missing documentation.</p> <p>3. The policy # 10112 dated 2/29/12 titled "RN SUPERVISORY VISITS" states, "A Registered Nurse shall make onsite visits to a patient's home no less frequently than every two (2) weeks [for a supervisory visit] when a patient is receiving skilled nursing care [home health aide and skilled services?]."</p>			