

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157596	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/18/2014
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NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 JOLIET ST STE 312 DYER, IN 46311
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N000000	This was a home health state relicensure survey.  Survey Date: March 11 - 18, 2014  Facility #: 7377  Medicaid #: 200873250  Surveyors: Ingrid Miller, MS, BSN, RN Public Health Nurse Surveyor  Skilled Patients: 116 patients  Quality Review: Joyce Elder, MSN, BSN, RN March 28, 2014	N000000		
N000440	410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable.  Based on document review and interview, the agency failed to ensure the organizational chart included speech therapy services for 1 of 1 agency with the potential to affect all the patients of the agency.  Findings	N000440	Speech Therapy Services provided by St JohnTherapy Services per long-standing contract. It will be the administrator responsibility to ensure that the organizational chart is maintained currentThe Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not	04/17/2014

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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N000442	<p>1. The agency's organizational chart, dated 2/19/09, failed to identify the agency had a speech therapist.</p> <p>2. On 3/17/14 at 11:15 AM, Employee A, the administrator / director of nursing, indicated the speech therapy services were part of the agency services. 410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency.</p> <p>Based on policy and administrative document review and interview, the agency failed to ensure that the governing body had appointed a qualified administrator, reviewed written by - laws, and oversaw the management and fiscal affairs of the agency for 1 of home health agency reviewed with the potential to affect all the patients of the agency.</p> <p>Findings</p> <p>1. On 3/13/14 at 10:15 AM, Employee A, the administrator / director of nursing indicated that the governing body had not had any meetings since 2012. Agency documents failed to evidence the governing body appointed a qualified administrator, reviewed</p>	N000442	<p>recur.IDR requested as agency has available documents. Thank you.</p> <p>TheGoverning Body meet on March 20, 2014 and appointed Lisa Magura BSN, RN as theadministrator and has delegated the authority and responsibilities for the provision of home care services inaccordance with state and federal regulations, accreditation standards and theagency mission. By laws have been adopted and reviewed. The POC has beenappointed and has subsequently met on April 7, 2014. An annual operationalbudget and capital expenditure plan has been developed. The personnel,administrative, and patient policies and procedures were reviewed. The members of the Governing Body are:</p>	

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	<p>written by - laws, and oversaw the management and fiscal affairs of the agency.</p> <p>2. A review of agency documents failed to show that the governing body had met in 2013 or 2014.</p> <p>3. On 3/17/14 at 11:15 AM, Employee A indicated the by - laws could not be found and there was no documentation showing the governing body appointed a qualified administrator, reviewed written by - laws, and oversaw the management and fiscal affairs of the agency.</p> <p>4. The agency policy titled "Governing Body" with no effective date stated, "The Governing Body shall assume full legal authority and responsibility for the operation of the agency ... to ensure lines of authority are established. To ensure patients are provided with appropriate, quality services. Special instructions The duties and responsibilities of the governing body shall include 1. Appoint a qualified administrator. Delegate to that individual the authority and responsibilities for the provision of home care services in accordance with state and federal regulations, accreditation stands, and agency mission. 2. Appoint the Professional Advisory Board ... as required by the state licensure and / or Medicare Conditions of Participation to guide the organization in the formulation and review of policies and procedures and ensure the highest quality of patient care 3. Adopt and periodically review and approve the administrative and personnel policies, patient care policies and procedures, by laws ... annual operating budget and capital expenditure plan. 4. Oversee the management and fiscal affairs of the agency."</p>		<p>JerryFozzard Owner, Lisa Magura BSN, RN Administrator. New members have been oriented tothe GB and their respective duties. A roster of membership of the GoverningBody has been implemented. The Governing Body will meet atleast annually and as needed. The Administrator will act as the liaison between the Governing Body and the Professional Advisory Committee. Documentation inthe form of GB minutes of the Governing Body meeting will be done with eachmeeting and reviewed and signed. The Administrator and Governing Body will beresponsible for monitoring of these corrective actions to ensure that thisdeficiency does not recur</p>	

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N000448	<p>410 IAC 17-12-1(c)(5) Home health agency administration/management Rule 12 Sec. 1(c)(5) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (5) Implement a budgeting and accounting system.</p> <p>Based on agency document review and interview, the home health agency failed to ensure the administrator implemented an effective budgeting and accounting system for 1 of 1 agency with the potential to affect all 116 active patients of the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of agency documents failed to evidence the administrator had implemented an effective budgeting and accounting system.</li> <li>On 3/17/14 at 11, the 11:15 AM, the administrator / director of nursing indicated there is no documentation showing the administrator had implemented an effective budgeting and accounting system.</li> </ol>	N000448	<p>Previous biller and administrator no longer with agency. Records reviewed by CEO and Medicare consultant Agency administrator to maintain all financial records to effectively manage budget and accounting system. Administrator working on effective budget and accounting system and developing a financial team. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</p>	04/17/2014
N000456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p>			

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N000458	<p>Based on document review and interview, the agency failed to ensure the ongoing quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. On March 17, 2014, at 11:15 AM, the administrator indicated there had been no completed quality assurance program since 2012.</p> <p>2. A review of quality assurance documents evidenced the quality assurance program had not occurred since 2012.</p>			N000456	<p>A Quality Improvement Plan has been established by the Administrator and DON that includes performance improvement indicators with tools for collection of data, acceptable target percentage for each indicator, quarterly chart audit committee, chart audit tool and a process tool for identifying and resolving issues and unmet targets. A performance improvement committee has been established.</p> <p>The Performance Improvement Committee will meet monthly and review all indicators for target goals and establish a plan of action for those targets that are not being met. The Chart audit committee will meet quarterly or more often and audit 10% of the clinical records to ensure compliance with all regulations regarding the clinical record and documentation there in.</p> <p>Administrator and DON will be responsible for monitoring the corrective action to assure this deficiency is corrected and will not recur.</p>		04/17/2014
N000458	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure,</p>						

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	<p>certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <ol style="list-style-type: none"> <li>(1) Receipt of job description.</li> <li>(2) Qualifications.</li> <li>(3) A copy of limited criminal history pursuant to IC 16-27-2.</li> <li>(4) A copy of current license, certification, or registration.</li> <li>(5) Annual performance evaluations.</li> </ol> <p>Based on personnel file and policy review and interview, the agency failed to ensure personnel files contained a signed job description, licenses, criminal history, annual evaluation, and orientation in 6 of 17 records reviewed (File A, F, H, I, K, O) of employee files reviewed with the potential to affect all the patients of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. Personnel file A, administrator / director of nursing, date of hire 12/30/13 and first patient contact 1/22/14, failed to evidence a signed job description for the administrator position.</li> <li>2. Personnel file F, contract occupational therapist with unknown date of hire and first patient contact, failed to show verification of occupational therapy license, criminal history verification, job description, and orientation.</li> <li>3. Personnel file H, registered nurse (RN), date of hire 1/3/11 and unknown first patient contact, failed to evidence an annual</li> </ol>	N000458	<p>All employee files to be audited for missing information. Missing physicals and Administrator job description were located in former alternate administrator's drawer in a mislabeled file. Documents placed in appropriate file. Physicals for RN A and C were performed prior to first patient contact. All missing nursing personnel TB testing located with physicals. Records were obtained for contracted (TRS) therapists F and O and found to be current. RN K is no longer employed with agency. Performance Evals for employee I to be presented to employee. Employee H is no longer employed with agency. Administrator conducted an audit of employee personnel files on March 25, 2014. On March 7, 2014, the administrator entered agreement with payroll company Paychex to audit and manage HR files, assist in developing formal orientation program and develop a more structured comprehensive</p>	04/17/2014

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	<p>evaluation since date of hire.</p> <p>4. Personnel file I, RN, date of hire 7/12/12 and first patient contact 7/14/12, failed to evidence an annual evaluation.</p> <p>5. Personnel file K, RN, date of hire 9/25/13 and first patient contact 1/23/13, failed to evidence a limited criminal history or expanded criminal history.</p> <p>6. Personnel file O, contract physical therapist with unknown date of hire and first patient contact, failed to show verification of physical therapy license, criminal history, job description, and orientation.</p> <p>7. The agency policy titled "License, Registration, or Certification Requirements" with no effective date stated, "If a position requires licensure, registration, or certification, it shall be the employee's responsibility to keep these documents current ... a copy of the employee's currently license certification shall be maintained in his / her personnel file."</p> <p>8. The agency policy titled "Performance Evaluations" with no effective date stated, "A competency based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter."</p> <p>9. The agency policy titled "Personnel Records" with no effective date stated, "Personnel files will be established and maintained for all personnel ... The personnel record for an employee will include ... criminal history and background checks as required by law ... licenses and certifications ... signed job descriptions ... orientation</p>		<p>employee manual. Administrator or designee will utilize employee checklist on all new employees and completeness will be checked by Administrator prior to first contact. All employees hired before March 2013 will receive performance evaluation. Competencies will be checked by outside agency for HHAs. All file audit by HR designee and paychex. Administrator will be responsible for monitoring the corrective action to assure this deficiency is corrected and will not recur.</p>	

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N000462	<p>checklist ... performance appraisals ... updated job descriptions ... physical, if required ... TB screening [2 step Mantoux] if new hire or proof of negative TB test at any time during the previous twelve months and result was negative or chest x - ray of evidence of treatment as indicated."</p> <p>10. On 3/17/14 at 5 PM, Employee A, administrator / director of nursing, indicated the above files were incomplete. 410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel record and policy review and interview, the agency failed to ensure personnel files contained a physical examination within 180 days of patient contact for 4 of 17 files reviewed with the potential to affect all the agency's patients and staff. (A, C, F, and O)</p> <p>Findings include:</p> <p>1. Personnel file A, administrator / director of nursing, date of hire 12/30/13 and first patient contact 1/22/14, failed to evidence a physical examination.</p>	N000462	All personnel files have been audited for compliance with a physical within 180 days of first patient contact and a statement indicating that the employee is free of communicable diseases. A tracking tool is in place to monitor date of physicals, statement of free of communicable diseases and date of first patient contact. An audit tool has been instituted to ensure compliance with the need for a physical within 180 days of first patient contact and indicates that the employee is free of communicable diseases. Prior to first patient contact the Administrator or designee will		

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	<p>2. Personnel file C, Registered Nurse (RN), date of hire 3/4/14 and first patient contact 3/4/14, failed to evidence a physical examination that showed the employee was free of communicable diseases.</p> <p>3. Personnel file F, contract occupational therapist with unknown date of hire and first patient contact, failed to evidence a physical examination.</p> <p>4. Personnel file O, contract physical therapist with unknown date of hire and first patient contact, failed to evidence a physical examination.</p> <p>5. The agency policy titled "Health Screening" stated, "Each employee having direct documentation of baseline health screening prior to providing care to patients. This includes, at a minimum, TB [tuberculosis] via the Mantoux method ... Preemployment physical examination will be performed by a physician or nurse practitioner as mandated by state law or agency policy ... On any employee or contract personnel providing direct patient care, there shall be documentation of completion of a tuberculin [TB] skin test, via the Mantoux method. OSHA requires two - step testing. If there is documented evidence of a negative skin test within the twelve months prior to employment, testing completed at the time of hire will fulfill the two step requirement. If the employee does not have documented evidence of a negative Mantoux skin test within the past twelve months, a Mantoux skin test will be given at the time of hire and repeated within three weeks of the first test."</p> <p>6. The agency policy titled "Personnel Records" with no effective date stated,</p>		<p>audit the personnel file for compliance with this regulation prior the employee having patient contact. 10% of the personnel files will be audited quarterly for compliance with physicals less than 180 days of first patient contact. Administrator will be responsible for monitoring the corrective action to assure this deficiency is corrected and will not recur.</p>				

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N000464	<p>"Personnel files will be established and maintained for all personnel ... The personnel record for an employee will include ... criminal history and background checks as required by law ... licenses and certifications ... signed job descriptions ... orientation checklist ... performance appraisals ... updated job descriptions ... physical, if required ... TB screening [2 step Mantoux] if new hire or proof of negative TB test at any time during the previous twelve months and result was negative or chest x - ray of evidence of treatment as indicated."</p> <p>7. On 3/17/14 at 5 PM, Employee A, administrator / director of nursing indicated the above files did not contain a physical examination.</p> <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: (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. (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. (3) Any person with:</p>			

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	<p>(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. (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). (5) Any person having a positive finding on 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 record and policy review and interview, the agency failed to ensure personnel files contained an annual tuberculosis screening for 2 of 17 files reviewed with the potential to affect all the agency's patients and staff. (F and O)</p> <p>Findings include:</p>	N000464	<p>All personnel files have been audited for compliance with a physical within 180 days of first patient contact and a statement indicating that the employee is free of communicable diseases. A tracking tool is in place to monitor date of physicals, statement of free of communicable diseases and date of first patient contact. An audit tool has been instituted to ensure compliance with the</p>	04/17/2014			

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	<p>1. Personnel file F, contract occupational therapist with unknown date of hire and first patient contact, failed to evidence annual tuberculosis screening.</p> <p>2. Personnel file O, contract physical therapist with unknown date of hire and first patient contact, failed to evidence annual tuberculosis screening.</p> <p>3. The agency policy titled "Health Screening" stated, "Each employee having direct documentation of baseline health screening prior to providing care to patients. This includes, at a minimum, TB [tuberculosis] via the Mantoux method ... Preemployment physical examination will be performed by a physician or nurse practitioner as mandated by state law or agency policy ... On any employee or contract personnel providing direct patient care, there shall be documentation of completion of a tuberculin [TB] skin test, via the Mantoux method. OSHA requires two - step testing. If there is documented evidence of a negative skin test within the twelve months prior to employment, testing completed at the time of hire will fulfill the two step requirement. If the employee does not have documented evidence of a negative Mantoux skin test within the past twelve months, a Mantoux skin test will be given at the time of hire and repeated within three weeks of the first test."</p> <p>4. The agency policy titled "Personnel Records" with no effective date stated, "Personnel files will be established and maintained for all personnel ... The personnel record for an employee will include ... criminal history and background checks as required by law ... licenses and certifications ... signed job descriptions ... orientation</p>		<p>need for a physical within 180 days of firstpatient contact and indicates that the employee is free of communicable diseases.Prior to first patient contact the Administrator or designee will audit the personnel file for compliance with this regulation prior the employee having patient contact. 10% of the personnel files will be audited quarterly for compliance with physicals less than 180 days of first patient contact. Administrator will be responsiblefor monitoring the corrective action to assure this deficiency is corrected andwill not recur.</p>		

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NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 JOLIET ST STE 312 DYER, IN 46311
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N000470	<p>checklist ... performance appraisals ... updated job descriptions ... physical, if required ... TB screening [2 step Mantoux] if new hire or proof of negative TB test at any time during the previous twelve months and result was negative or chest x - ray of evidence of treatment as indicated."</p> <p>5. On 3/17/14 at 5 PM, Employee A, administrator / director of nursing indicated the above files were incomplete. 410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and professional standard review, the agency failed to ensure its staff had provided services in accordance to professional standards in 2 of 3 home visit observations (patient #6 and 7) completed creating the potential to affect any patients cared for by this registered nurse. (Employees E and I)</p> <p>The findings include</p> <p>1. On 3/13/14 at 3:30 PM, Employee E, home health aide, was observed to give a partial bath to patient #6. Employee E did not change gloves during the course of this bath despite changing the water in the basin before washing the peri area. She washed the patient's face, arms, chest, back, legs, feet, perineal area, anal area, and buttocks in that order without changing her gloves. She</p>	N000470	<p>Employee E re-educated on gloving during bathing according to Administrative Standards for the ISDH Nurse Aide Training Manual. Employee Ire-educated on Hand washing Technique per Policy D330 of Clinical Procedure Manual HomeHealth Aide staff re-in-service on Topic 17 Bathing, Procedure 33 bed bath and Procedure 2 gloves (Administrative Standards for the Indiana State Dept. of Health Nurse Aide Training Program). All nursing staff re-educated on Handwashing Procedure D330 of Clinical Procedure Manual. Administrator or designee observe Random hand washing and proper gloving by observing all home health aides and nurses. Administrator will be responsible for monitoring these</p>	

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N000472	<p>obtained a clean wash cloth for the peri care wash and changed the water before this time of the bath.</p> <p>a. On 3/14/14 at 4:20 PM, the administrator / director of nursing indicated the gloves should have been changed after washing the rectal area. She indicted she had given the agency procedure to the employee last week. She indicated that she would give this policy to the observer.</p> <p>b. On 3/17/14 at 5:10 PM, the agency was unable to provide a procedure for giving a bath.</p> <p>2. On 3/17/14 at 2:40 PM at a home visit observation, Employee I, Registered Nurse, was observed to wash her hands prior to caring for Patient #7. She washed her hands with bar soap found in the patient's bathroom for 30 seconds and then dried with a paper towel.</p> <p>a. On 3/17/13 at 3:55 PM, the administrator / director of nursing indicated Employee I should not use bar soap for hand washing prior to patient care.</p> <p>b. A nursing procedure titled "Infection Prevention: Keeping it clean" with a date of March / April 2009 stated, "Wet your hands and wrists with warm water, and apply soap from a dispenser. Don't use bar soap because it allows cross-contamination. This was retrieved on 3/21/14 at 11 PM at <a href="http://www.nursingcenter.com/lnc/static?pageid=944542#sthash.x6HE6lc7.dpuf">http://www.nursingcenter.com/lnc/static?pageid=944542#sthash.x6HE6lc7.dpuf</a> 410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and</p>		corrective actions and will be reviewed each quarterly qualitymeeting to ensure this deficiency does not recur.	

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	<p>evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on document review and interview, the agency failed to ensure the ongoing quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. On March 17, 2014, at 11:15 AM, the administrator indicated there had been no completed quality assurance program since 2012.</li> <li>2. A review of quality assurance documents evidenced the quality assurance program had not occurred since 2012.</li> </ol>	N000472	<p>A Quality Improvement Plan has been established by the Administrator and DON that includes performance improvement indicators with tools for collection of data, acceptable target percentage for each indicator, quarterly chart audit committee, chart audit tool and a process tool for identifying and resolving issues and unmet targets. A performance improvement committee has been established. The Performance Improvement Committee will meet monthly and review all indicators for target goals and establish a plan of action for those targets that are not being met. The Chart audit committee will meet quarterly or more often and audit 10% of the clinical records to ensure compliance with all regulations regarding the clinical record and documentation there in. Administrator and DON will be responsible for monitoring the corrective action to assure this deficiency is corrected and will</p>	04/17/2014	

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N000494	<p>410 IAC 17-12-3(a)(1)&amp;(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on agency document review, policy review, clinical record review, and interview, the agency failed to ensure patients were informed of their rights prior to the rendering of care in 2 of 12 clinical records reviewed with the potential to affect all the patients of the agency. (# 2, 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 2, start of care 2/19/14, failed to evidence the patient had been notified of the patient rights.</li> <li>Clinical record #9, start of care 12/11/13, failed to evidence the patient had been notified of the patient rights.</li> <li>On 3/18/14 at 10:45 AM, Employee A, the administrator / director of nursing indicated the documentation of the patient rights'</li> </ol>	N000494	<p>notrecur.</p> <p>Administrator has In-serviced nursing staff on Patient Rights. Patients re-educated and received Patients' Rights and current Indiana Advanced Directives (2013). Patients and Responsible Parties sign new consents to acknowledge they received their rights and responsibilities and copy placed in each chart. Each new admission packet will be updated. All new admission packets will be reviewed for completeness by Administrator or designee. All new patient packets will be audited. Administrator to audit 10% of existing patient charts weekly for compliance. The Administrator will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will</p>				

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N000514	<p>acknowledgement was not in the records noted above.</p> <p>4. The agency policy titled "Home Care Bill of Rights / Grievance procedure" with no effective date stated, "Patients will be informed of their right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. Agency will provide a mechanism in which a patient's complaint can be processed and resolved promptly and efficiently ... To protect and promote the exercise of patient's rights."</p> <p>5. The agency document titled "Patient bill of rights and responsibilities" with no effective date stated, "The Patient or patient's legal representative has the right to be informed of the patient's rights through effective means of communication. the home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. the home health agency shall maintain documentation showing that it has complied with the requirements of this section."</p> <p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished.</p>		<p>not recur. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</p>	

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	<p>(B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency.</p> <p>(2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on policy review, clinical record review, administrative document review, and interview, the agency failed to follow their own policy to investigate complaints and document the existence and resolution of the complaint for 1 of 1 agency reviewed with the potential to affect all of the patients served by the agency.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to place a complaint with the department regarding treatment or care furnished by a home health agency ... to voice complaints about care or treatment ... the organization investigates the complaint and resolution of the same."</li> <li>The agency admission package contained a document titled "Patient Bill of Rights and Responsibilities."</li> <li>Clinical record #12, start of care 10/23/13, evidenced the patient had received the patient rights at the start of care.</li> <li>On 3/14/14 at 9:17 AM, patient #12 indicated via phone call that he / she had filed</li> </ol>	N000514	<p>All staff have been instructed on the policy and process for receiving, documenting and resolving patient grievances. Staff has been instructed on the use of the complaint log, patient grievance form and that all patient grievances or concerns are to be brought to the attention of the DON and/or the Administrator in a timely manner for follow up, investigation and resolution. Staff will be in-serviced on hire, annually and as necessary on the right of patient to have grievances acknowledged and fully investigated and informed of the resolution of their grievance as outlined in the Grievance Policy. The DON and/or the administrator will review all grievances and ensure that investigation, resolution and documentation take place. The DON and the Administrator will be responsible for monitoring and ensuring that this deficiency does not recur.</p>	04/17/2014

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N000518	<p>a complaint due to lack of requested toenail care and also lack of home health aide services as had been planned with care planning. Patient #12 had complained to agency staff several times about the lack of these services and did not know of any investigation or resolution of these complaints. The complaints had been filed in January and February 2014.</p> <p>5. On 3/14/14 at 2:45 PM, the administrator indicated the complaint had not been filed in the complaint log.</p> <p>6. A review of the complaint log and other agency documentation failed to evidence any investigation or other documentation concerning the complaint filed by patient #12. 410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review, observation, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced directives, including a description of applicable State law, in 12 of 12 records reviewed (#1 - 12) with the potential to affect all the active patients of the agency.</p>	N000518	Allchart are being audited for deficient practices. Administrator re-educated nursing staff on Patient Rights. Patients re-educated and received Patients' Rights and current Indiana Advanced Directives (2013). Patients and Responsible Parties sign new consents to acknowledge they received their rights and	

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	<p>Findings include</p> <ol style="list-style-type: none"> <li>1. The admission book given to the patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana advanced directives in the admission folder that was distributed to the patients at the start of care (SOC).</li> <li>2. On 3/14/14 at 2 PM, the administrator / director of nursing indicated the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013) in patients #5, #6, #7 home admission books and that all the patients of the agency needed to receive the updated advanced directives.</li> <li>3. Clinical record #1, SOC 1/17/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</li> <li>4. Clinical record #2, SOC 12/11/13 failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. There was no evidence in the record that the patient had received the patient rights.</li> <li>5. Clinical record #3, SOC 10/24/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</li> <li>6. Clinical record #4, SOC 10/21/10, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</li> </ol>		<p>responsibilities and acopy placed in each chart. Each new admission packet will be updated. All new admission packets will be reviewed for completeness by Administrator or designee. All new patient packets will be audited. Administrator to audit 10% of existing patient charts weekly for compliance. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</p>				

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	<p>7. Clinical record #5, SOC 12/30/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 3/13/14 at 11 AM, the home admission book was observed in the home for patient #5. The book did not contain the Indiana Advanced Directives effective May 2004 and revised July 1, 2013.</p> <p>8. Clinical record #6, SOC 11/2/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 3/13/14 at 3:30 PM, the home admission book was observed in the home for patient #6. The book did not contain the Indiana Advanced Directives effective May 2004 and revised July 1, 2013.</p> <p>9. Clinical record #7, SOC 7/26/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 3/17/14 at 1:10 PM, the home admission book was observed in the home for patient #7. The book did not contain the Indiana Advanced Directives effective May 2004 and revised July 1, 2013.</p> <p>10. Clinical record #8, SOC 11/7/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient had signed that the document was received on the SOC date.</p>			

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N000520	<p>11. Clinical record #9, SOC 11/7/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient had not received the patient rights.</p> <p>12. Clinical record #10, SOC 5/3/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>13. Clinical record #11, SOC 2/27/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>14. Clinical record #12, SOC 10/23/13 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on policy review, clinical record review, administrative document review, and interview, the agency failed to meet the needs of 1 of 12 clinical records reviewed ( #2) with the potential to affect any patient of the agency.</p> <p>Findings include</p>	N000520	<p>Patient 12 had requested podiatrist care. On2/26/14 Administrator notified of request, order was not in chart at that time. Contacted Home Physicians to request podiatry service at request of patient. 3/3/14Received call back from Home physicians indicating patient has changed insurance</p>	

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	<p>1. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 10/23/13 - 12/21/13 and failed to include a plan of care for the next certification period of 12/22/13 - 2/19/14 or the current certification period that has unknown dates. The patient is still an active patient and filed a complaint due to the lack of home health aide services needed and the lack of a podiatrist's care despite an order for this. There was no documentation in the record that the patient received care from a podiatrist. There were no aide visits noted in the record. The patient had signed receiving the patient rights at the start of care.</p> <p>a. A clinical record document titled "Fax" and a date of 11/21/13 stated, "Patient to see podiatrist." This was signed by the physician and Employee I, RN.</p> <p>b. On 3/14/14 at 9:17 AM, patient #12 indicated via phone call that he / she had filed a complaint due to lack of requested toe nail care and also lack of home health aide services as had been planned with care planning. Patient #12 indicated the patient had complained to agency staff several times about the lack of these services and did not know of any investigation or resolution of these complaints. The complaints had been filed in January and February 2014.</p> <p>c. A review of the complaint log failed to evidence this complaint.</p> <p>d. On 3/14/14 at 2:45 PM, the administrator indicated the complaint had not been filed in the complaint log and the plan of care was not in the record for recertification periods</p>		<p>from Medicare to Humana. Home podiatry not covered under policy. 3/3/14informed patient that he does not have insurance coverage for podiatry underHumana. That admin had phoned several podiatrists to no avail and informed hecan go outpatient. Patient to contact insurance or Medicare. 3/12/14 followedup with patient. He stated he contacted Humana. HIQ shows patient "Null" ininsurance coverage. Informed by primary physician that Medicare will be resumedon 4/1/14. Informed patient. Patient states not sure if he needs aide serviceat this time. Patient denies complaint. Patient stated very grateful for assistin insurance benefit information. Nursing staff re-educated on grievanceprocedure and patients re-educated on grievance procedure. All new admissionpackets will be reviewed for completeness by Administrator or designee. Admitting RN will be notified if any discrepancies.</p>	

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N000522	<p>and indicated no documentation was present about the home health aide services or lack of a podiatrist visit.</p> <p>e. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as a patient of the home health agency as follows ... the patient has the right to place a complaint with the department regarding treatment or care furnished by a home health agency ... to voice complaints about care or treatment ... the organization investigates the complaint and resolution of the same."</p> <p>2. The agency policy titled "Patient Admission Process" with no effective date stated, "If the agency cannot fulfill the required health need, a referral will be made to other appropriate community resources and referral source will be notified."</p> <p>3. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs." 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>			

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	<p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure treatments and services had been provided in accordance with physician's orders in 7 of 12 records (2, 3, 4, 7, 8, 9, 12) reviewed creating the potential to affect all of the agency's 116 active patients.</p> <p>Findings</p> <p>1. Clinical record #2, Start of care (SOC) 12/11/13 and primary diagnosis of asthma and other diagnoses of renal failure, abnormality of gait, urinary incontinence, and benign hypertension, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 for the skilled nurse to do a skilled assessment, disease process management, skilled teaching, cardiopulmonary, nutrition / elimination, signs and symptoms of infection, teach disease process, home / safety / falls prevention, medication teaching, evaluate medication effects and compliance, pulse oximetry every visit. The record failed to evidence the skilled nurse performed these tasks.</p> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the plan of care had not been followed at the above initial assessment.</p> <p>2. Clinical record #3, SOC 10/24/13 and primary diagnosis of Alzheimer's disease, included a POC established by the physician for the certification period of 12/23/13 - 2/20/14 for the skilled nurse to visit the patient 1 - 2 times a week for 9 weeks. The</p>	N000522	<p>The DON has in-serviced the professional staff on following the POC, ensuring that all treatments, equipment, medications and disciplines are documented on the POC and all interventions, teaching, assessments and treatments are outlined in detail and completed on the patient visit. Education provided on following the frequency and duration of visits established on the POC. The professional staff was instructed that all care on the POC must be completed and any alteration/additional care needs for the patient must have a written order to be performed. 100% of the clinical records have audited for the above deficiencies and have been addressed with the appropriate professional. The clinical documentation will be reviewed by the DON for compliance with the POC, all treatments, assessments, teaching and procedures as outlined on the POC. 10% of the clinical records will be audited quarterly for compliance with the care, interventions, treatments, teaching and assessments as outlined on the POC. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>	04/17/2014

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	<p>skilled nurse was to do a skilled health management and observation. The skilled nurse failed to assess the patient's pain level on 2/5/14.</p> <p>On 3/14/ 14 at 1:56 PM, the administrator / director of nursing indicated the plan of care was not followed at the 2/5/14 visit.</p> <p>3. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/2/14 - 4/4/14 and evidenced the plan of care was not followed.</p> <p>a. This plan of care evidenced the skilled nurse (SN) was to visit 1 -2 times a week for 9 weeks and the home health aide (HHA) was to visit 1 - 2 times a week for 9 weeks. The record evidenced skilled nurse visits on 2/5, 2/13, 2/19, 2/26 and HHA visits on 2/5/14. There were no other SN and HHA visits in the record.</p> <p>b. Additionally, this plan of care included orders for the skilled nurse to give Vitamin B12 1000 mcg per ml monthly subcutaneous. This medication was documented as being given in the antecubital space on February 26, 2014, by Employee J, registered nurse (RN). It was not documented if this was given as an intramuscular injection or subcutaneous injection.</p> <p>c. Via telephone call, on 3/14/14 at 12:30 PM, Patient #4 indicated that the registered nurse, Employee J, had given the Vitamin B 12 injection into the upper left arm at the last visit.</p> <p>d. On 3/14 2:20 PM, the administrator / director of nursing indicated the Vitamin B12</p>			

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	<p>injection was to be given subcutaneous and this was not documented and did not follow the plan of care. Employee A indicated the nurse had written in error that the injection had been given into the antecubital space.</p> <p>4. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 1/22/14 - 3/22/14, with orders for a weight to be completed at each visit.</p> <p>a. On 3/17/14 at 1:10 PM, during a home visit, Employee I, RN, failed to weigh the patient.</p> <p>b. On 3/18/13 at 3:55 PM, the administrator / director of nursing indicated the plan of care was not followed at the home visit observation.</p> <p>4. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 11/7/13 - 1/5/14 with orders for physical therapy and occupational therapy, and no orders for glucose testing.</p> <p>a. The plan of care for the certification period of 11/7/13 - 1/5/14 evidenced that the patient was to receive physical therapy 1 - 2 times a week for 5 weeks and Occupational therapy visits 1 - 2 times a week for 5 weeks. No visits were made.</p> <p>b. The plan of care evidenced the skilled nurse was to visit one times a week for 9 weeks. The only visits in the record were on 11/15/13, 11/23/13, 11/29/13, and 12/5/13. There was no visit for the first week of care (11/7/13 - 11/9/13). The skilled nurse did not have orders to check blood sugars on the</p>			

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	<p>plan of care, but did check the blood sugars on 11/15/13, 11/23/13, 11/29/13, and 12/5/13.</p> <p>c. On 3/14/14 at 3:18 PM, the administrator / director of nursing indicated the above visits and lack of visits did not follow the plan of care.</p> <p>5. Clinical record #9, SOC 2/19/14 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/19/14 - 4/19/14 without orders for wound care to the right great toe. Treatment orders included a skilled assessment, disease process management, skilled teaching. Skilled nurse to assess compliance with therapeutic regimen, medication teaching, evaluate medication effects and compliance, assess for skin condition, wound care, and teach measures to minimize skin infections. Assess for response to pain management. Skilled nurse visits were to be made 1 - 2 times a week.</p> <p>a. A clinical record visit note dated 2/26/14 and completed by Employee G, RN, failed to show what the wound measurements were and what cream was applied to the wound. There was no pain assessment on this visit note. There was no documentation of medication teaching or evaluation of the medication effects and compliance. There was no assessment for response to pain management. There was no documentation about response to pain management.</p> <p>b. A clinical record nursing visit note dated 3/5/14 and completed by Employee G, RN, evidenced the wound on the right great toe had no length, no depth, no drainage, no tunneling, no odor, and no stoma. The</p>			

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	<p>skilled nurse documented, "Cleansed right great toe with normal saline and applied cream and covered with sterile 4 by 4 and taped." There was no documentation by the skilled nurse about the medication assessment or teaching.</p> <p>6. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 10/23/13 - 12/21/13, but failed to include a plan of care for the next certification period of 12/22/13 - 2/19/14. The skilled nurse made visits on 12/22/13, 12/30/13, 1/13/14, and 2/4/14. There were no other visits noted in the record past this time frame.</p> <p>On 3/14/14 at 2:45 PM, the administrator / director of nursing indicated the plan of care was not in the record for this certification period.</p> <p>7. The agency policy titled "Medical Supervision" with no effective date stated, "A physician plan of care is developed for each patient at the time of admission and signed by the physician in the appropriate time frame ... agency responsibilities include prompt reporting of a change in patient condition ... support of a physician plan of care."</p> <p>8. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs."</p>			

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N000524	<p>9. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of care signed by the physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care."</p> <p>10. The agency policy titled "Pain Assessment" with no effective date stated, "Pain is assessed at every home visit and documented on a pain or symptom flow sheet."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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.</p>			

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	<p>(B) Cover all pertinent diagnoses. (C) Include the following: (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 home visit observation, clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all required elements for 9 of 12 records reviewed (#1, #2, #3, #4, #6, #7, #8, #9, #12) with skilled nursing with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #1, primary diagnosis of Osteoarthritis and start of care (SOC) date 1/17/14, contained a plan of care (POC) for 1/17/14 - 3/17/14 that stated, "Care by 3/17/14." There were no measurable goals or outcomes for this patient.</p> <p>On 3/14/14 at 2:35 PM, Employee A, the administrator / director of nursing, indicated the goals on the plan of care were not</p>	N000524	All charts audited for the deficient practices. 84% of nurses no longer employed with agency and 100% office staff no longer with agency.(1,2)All patients identified with incomplete plan of care documentation wereclarified with physician, completed and appropriately submitted to the patients physician. (4,7)Nurses educated on mandatory requirement of signing plan of care and submitting within 48 hours of completion of assessment. (5) Nurses educated on mandatory requirement of obtaining and adhering to physician ordered frequencies. Education to RN case mangers provided on the need to establish and document measurable goals on the POC. A fax log and tracking system of	04/17/2014			

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	<p>measurable.</p> <p>2. Clinical record #2, primary diagnosis of asthma and SOC date 12/11/13, contained a POC for 12/11/13 - 2/8/14 with orders for skilled nurse visits 1 - 2 times a week for 9 weeks. There were no measurable goals or outcomes for this patient. The physician's signature on this POC was dated 1/14/14.</p> <p>On 3/14/14 at 3:50 PM, Employee A indicted the goals on this plan of care were not measurable.</p> <p>3. Clinical record #3, primary diagnosis of Alzheimer's disease and SOC date of 10/24/13, contained a POC for 12/23/13 - 2/20/14 with orders for skilled nurse visits 1 - 2 times a week. The POC failed to evidence a timely signature of the physician with a physician's signature on 2/4/14. The skilled nurse had not signed the verbal order in box 23 of this POC. This POC lacked measurable goals.</p> <p>On 3/14/14 at 1:57 PM, Employee A indicated the registered nurse had not signed the POC and the physician had not signed the POC and the goals on the POC were not measurable.</p> <p>4. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/2/14 - 4/2/14 that failed to evidence a nurse's signature and date of verbal order and a physician's signature.</p> <p>On 3/11/14 at 4:35 PM, Employee A indicated the POC failed to include a doctor's signature or nurse's signature.</p>		<p>checking for returned signed POC and verbal orders established; education provided to professional staff on the need for physician orders for all care and treatments to be provided to the patient. (6) Nurses educated on completing plan of care in entirety and list any and all DME and equipment. (8) Nurse identified for this patient is no longer employed with agency. (9) Nursing educated regarding the requirement of an active plan of care in order to provide services for patient. The DON/Alternate DON or nursing designee will audit 10% of charts weekly to ensure completion of plan of care, and that it is appropriate for patient. The DON/Alternate DON or nursing designee will monitor all patient start of care and re-certifications for appropriate, complete and timely submission of the plan of care. All plan of cares will be monitored to include appropriate signatures and dates. The DON/Alternate DON or nursing designee will monitor all scheduling and clinical documentation to be in compliance with the frequencies noted on the plan of care. Axxess system transition will provide numerous auditing and tracking systems and submissions will be more timely as it is electronic. The DON/Alternate DON or nursing designee will be responsible for monitoring these corrective actions and will be</p>		

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	<p>5. Clinical record #6, SOC 11/2/13 and primary diagnosis of pressure ulcer stage 1, included a plan of care for the certification period of 3/2/14 - 4/30/14 that failed to evidence the frequency and duration of the home health aide (HHA) and skilled nurse (SN) visits. SN visits occurred on 3/4/14 and the HHA visits occurred on 3/1/14, 3/4/14, 3/6/14 and 3/13/14.</p> <p>On 3/14/14 at 2 PM, Employee A, administrator and director of nursing, indicated the frequency and duration of skilled nurse and HHA visits were not on the plan of care.</p> <p>6. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 1/22/14 - 3/22/14, that failed to evidence the patient had a wheelchair and walker.</p> <p>a. On 3/17/14 at 1:10 PM, it was obverted that the patent had a wheelchair and walker.</p> <p>b. On 3/18/13 at 3:55 PM, Employee A indicated the plan of care was not complete.</p> <p>7. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 11/7/13 - 1/5/14 that failed to evidence a nursing signature with the verbal order or a physician order for this plan of care.</p> <p>On 3/14/14 at 3:18 PM, Employee A, administrator, failed to evidence a physician's signature or verbal order to start care.</p> <p>8. Clinical record #9, start of care (SOC) 2/19/14 and primary diagnosis of diabetes, included a plan of care for the certification</p>		<p>reviewed at quarterly to ensure the deficiency is corrected and will not recur.</p>				

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	<p>period of 2/19/14 - 4/19/14 without orders for wound care to the right great toe. Treatment orders included wound care but the plan of care did not specify the type of wound care to be provided.</p> <p>9. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 10/23/13 - 12/21/13, but failed to include a plan of care for the next certification period of 12/22/13 - 2/19/14. The skilled nurse made visits on 12/22/13, 12/30/13, 1/13/14, and 2/4/14. There were no other visits noted in the record past this time frame.</p> <p>On 3/14/14 at 2:45 PM, Employee A indicated the plan of care was not in the record for this certification period.</p> <p>10. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of car signed by the physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days.</p>			

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N000527	<p>Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care." 410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care for 2 of 12 records reviewed (4 and 12) with the potential to affect all of the agency's active patients.</p> <p>Findings</p> <p>1. Clinical record #4, start of care (SOC) 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/21/14 - 4/12/14 with orders for the skilled nurse to monitor foot care closely and to do skilled assessment and disease process management. At skilled nurse visits on 2/13/14 and 2/19/14 the skilled nurse documented changes in the patients condition that were not updated with the physician.</p> <p>a. A clinical record document titled "Skilled Nursing Note" with a date of 2/13/14 and signed by Employee J, Registered Nurse, stated, "Purplish feet ... burning and tingling [in legs]." The record failed to evidence the</p>	N000527	The Administrator/DON have conducted in-services with all nursing staff to address the regulations, policies and procedures on following the established plan of care, evaluating and re-evaluating the patient's on-going needs and notifying the physician in any change in patient condition and needs; the process of reporting changes and needs to the physician promptly. Travel charts have been established to include all necessary documents including the POC. 100% of the records have been audited with education provided to the nursing staff on deficiencies noted. Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes inpatient condition. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this	

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N000532	<p>physician had been notified.</p> <p>b. A clinical record document titled "Skilled Nursing Note" with a date of 2/19/14 and time of 9:45 AM and signature of Employee J stated, "States ... feet feel cold and numb today. Purplish color." The record failed to evidence the physician had been notified.</p> <p>c. On 3/14/14 at 2:30 PM, the administrator / director of nursing indicated the doctor had not been notified of the patient's complaint and change of condition."</p> <p>2. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a start of care assessment on 10/23/13 where the skilled nurse had documented the patient's pain level was a "6" on a numerical scale of "1 - 10." ("1" is the lowest and "10" is the highest).</p> <p>On 3/14/14 at 2:55 PM, Employee A indicated the pain level was not reported to the physician. 410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on clinical record review and interview, the agency failed to ensure the agency staff promptly alerted the physician to any</p>			N000532	<p>deficiency is corrected and will not recur.</p> <p>The Administrator/DON have conducted in-services with all nursing staff to address the regulations,policies and procedures on following the</p>		

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	<p>changes that suggest a need to alter the plan of care for 2 of 12 records reviewed (4 and 12) with the potential to affect all of the agency's active patients.</p> <p>Findings</p> <p>1. Clinical record #4, start of care (SOC) 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/21/14 - 4/12/14 with orders for the skilled nurse to monitor foot care closely and to do skilled assessment and disease process management. At skilled nurse visits on 2/13/14 and 2/19/14 the skilled nurse documented changes in the patients condition that were not updated with the physician.</p> <p>a. A clinical record document titled "Skilled Nursing Note" with a date of 2/13/14 and signed by Employee J, Registered Nurse, stated, "Purplish feet ... burning and tingling [in legs]." The record failed to evidence the physician had been notified.</p> <p>b. A clinical record document titled "Skilled Nursing Note" with a date of 2/19/14 and time of 9:45 AM and signature of Employee J stated, "States ... feet feel cold and numb today. Purplish color." The record failed to evidence the physician had been notified.</p> <p>c. On 3/14/14 at 2:30 PM, the administrator / director of nursing indicated the doctor had not been notified of the patient's complaint and change of condition."</p> <p>2. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a start of care assessment on 10/23/13 where the skilled nurse had documented the</p>		<p>established plan of care, evaluating and re-evaluating the patient's on-going needs and notifying the physician in any change in patient condition and needs; the process of reporting changes and needs to the physician promptly. Travel charts have been established to include all necessary documents including the POC. 100% of the records have been audited with education provided to the nursing staff on deficiencies noted. Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>		

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N000537	<p>patient's pain level was a "6" on a numerical scale of "1 - 10." ("1" is the lowest and "10" is the highest).</p> <p>On 3/14/14 at 2:55 PM, Employee A indicated the pain level was not reported to the physician. 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 clinical record and agency policy review, observation, and interview, the agency failed to ensure skilled nursing services had been provided by the registered nurse with physician's orders in 6 of 12 records (2, 3, 4, 7, 8, 9) reviewed creating the potential to affect all of the agency's 116 active patients.</p> <p>Findings</p> <p>1. Clinical record #2, Start of care (SOC) 12/11/13 and primary diagnosis of asthma and other diagnoses of renal failure, abnormality of gait, urinary incontinence, and benign hypertension, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 for the skilled nurse to do a skilled assessment, disease process management, skilled teaching, cardiopulmonary, nutrition / elimination, signs and symptoms of infection, teach disease process, home / safety / falls prevention, medication teaching, evaluate medication effects and compliance, pulse</p>	N000537	The DON has in-serviced the professional staff on following the POC, ensuring that all treatments, equipment, medications and disciplines are documented on the POC and all interventions, teaching, assessments and treatments are outlined in detail and completed on the patient visit. Education provided on following the frequency and duration of visits established on the POC. The professional staff was instructed that all care on the POC must be completed and any alteration/additional care needs for the patient must have a written order to be performed. 100% of the clinical records have audited for the above deficiencies and have been addressed with the appropriate professional. The clinical documentation will be reviewed by the DON for compliance with the POC, all treatments, assessments, teaching and procedures as outlined on the POC. 10% of the	

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	<p>oximetry every visit. The record failed to evidence the skilled nurse performed these tasks at the initial assessment.</p> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the plan of care had not been followed at the above initial assessment.</p> <p>2. Clinical record #3, SOC 10/24/13 and primary diagnosis of Alzheimer's disease, included a POC established by the physician for the certification period of 12/23/13 - 2/20/14 for the skilled nurse to visit the patient 1 - 2 times a week for 9 weeks. The skilled nurse was to do a skilled health management and observation. The skilled nurse failed to assess the patient's pain level on 2/5/14.</p> <p>On 3/14/ 14 at 1:56 PM, the administrator / director of nursing indicated the plan of care was not followed at the 2/5/14 visit.</p> <p>3. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/2/14 - 2/4/14 and evidenced the plan of care was not followed.</p> <p>This plan of care evidenced the skilled nurse (SN) was to visit 1 -2 times a week for 9 weeks. The record evidenced skilled nurse visits on 2/5, 2/13, 2/19, 2/26/14. There were no other SN visits in the record.</p> <p>4. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 1/22/14 - 3/22/14, with orders for a weight to be completed at each visit.</p>		clinical records will be audited quarterly for compliance with the care, interventions, treatments, teaching and assessments as outlined on the POC . The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.	

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	<p>a. On 3/17/14 at 1:10 PM, during a home visit, Employee I, RN, failed to weigh the patient.</p> <p>b. On 3/18/13 at 3:55 PM, the administrator / director of nursing indicated the plan of care was not followed at the home visit observation.</p> <p>5. Clinical record #8, SOC 11/7/13 and primary diagnosis of diabetes, included a plan of care for the certification period of 11/7/13 - 1/5/14 that failed to evidence orders for glucose testing.</p> <p>The plan of care evidenced the skilled nurse was to visit one times a week for 9 weeks. The only visits in the record were on 11/15/13, 11/23/13, 11/29/13, and 12/5/13. There was no visit for the first week of care (11/7/13 - 11/9/13). The skilled nurse did not have orders to check blood sugars on the plan of care, but did check the blood sugars on 11/15/13, 11/23/13, 11/29/13, and 12/5/13.</p> <p>6. Clinical record #9, SOC 2/19/14 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/19/14 - 4/19/14 without orders for wound care to the right great toe. Treatment orders included a skilled assessment, disease process management, skilled teaching. Skilled nurse to assess compliance with therapeutic regimen, medication teaching, evaluate medication effects and compliance, assess for skin condition, wound care, and teach measures to minimize skin infections. Assess for response to pain management. Skilled nurse visits were to be made 1 - 2 times a week.</p>				

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	<p>a. A clinical record visit note dated 2/26/14 and completed by Employee G, RN, failed to show what the wound measurements were and what cream was applied to the wound. There was no pain assessment on this visit note. There was no documentation of medication teaching or evaluation of the medication effects and compliance. There was no assessment for response to pain management. There was no documentation about response to pain management.</p> <p>b. A clinical record nursing visit note dated 3/5/14 and completed by Employee G, RN, evidenced the wound on the right great toe had no length, no depth, no drainage, no tunneling, no odor, and no stoma. The skilled nurse documented, "Cleansed right great toe with normal saline and applied cream and covered with sterile 4 by 4 and taped." There was no documentation by the skilled nurse about the medication assessment or teaching.</p> <p>7. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs."</p> <p>8. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family</p>			

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N000540	<p>and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of care signed by the physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care."</p> <p>9. The agency policy titled "Pain Assessment" with no effective date stated, "Pain is assessed at every home visit and documented on a pain or symptom flow sheet." 410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse completed the initial assessment visit to determine the immediate care and support needs of the patients for 1 of 12 records</p>	N000540	The DON has in-serviced the professional staff on following the POC, ensuring that all treatments, equipment, medications and disciplines are documented on the POC and all interventions, teaching,	

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N000542	<p>reviewed (1) with the potential to affect all new patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #1 identified a start of care (SOC) date of 1/17/14. The initial assessment was not completed. There was no referral date in the record.</p> <p>2. On 3/14/13 at 2:35 PM, Employee A, the administrator / director of nursing, indicated the initial assessment was not in the record.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p>	N000542	<p>assessments and treatments are outlined in detail and completed onthe patient visit. Education provided onfollowing the frequency and duration of visits established on the POC. Theprofessional staff was instructed that all care on the POC must be completed and any alteration/additional care needs for the patient must have a written order to be performed. 100% of the clinical records have audited for the above deficiencies and have been addressed with the appropriate professional. The clinical documentation will be reviewed by the DON for compliance with the POC, all treatments, assessments, teaching and procedures as outlined on the POC. 10% of the clinical records will be audited quarterly for compliance with the care, interventions,treatments, teaching and assessments as outlined on the POC . The DON will be responsible for monitoring the corrective actions to ensure this deficiency is correctedand will not recur.</p> <p>The DON has conducted in-services with all RN case</p>				

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N000546	<p>Based on clinical record review and interview, the agency failed to ensure the registered nurse reevaluated the patient's need at least every 60 days for 2 of 7 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days. (#2 and #4).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #2, Start of care (SOC) 12/11/13, included a plan of care (POC) established by the physician for the certification period of 12/11/13 - 2/8/14 and 2/9/14 - 4/9/14. The record failed to evidence the registered nurse completed a comprehensive recertification assessment.</li> </ol> <p>On 3/14/14 at 3:55 PM, the administrator / director of nursing indicated the recertification assessment was not in the record.</p> <ol style="list-style-type: none"> <li>Clinical record #6, SOC 11/2/13, included plans of care for the certification periods of 1/1/14 - 3/1/14 and 3/2/14 - 4/30/14. The record failed to evidence the registered nurse had completed a comprehensive recertification assessment.</li> </ol> <p>On 3/14/14 at 2:10 PM, the administrator / director of nursing indicated the recertification assessment was not in the record.</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a)(1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in</p>		<p>management staff on the need for a timely recertification comprehensive assessment on every patient within the 56-60 day window, the need for the assessment to be complete with all elements addressed and accurate. 100% of the clinical records have audited for the above deficiencies and have been addressed with the appropriate professional. The clinical documentation will be reviewed by the DON for compliance with completion of the recertification comprehensive assessment and that it falls within the 56-60 day window. A tracking tool has been developed to alert the RN case managers for pending recertification timelines. 10% of the clinical records will be audited quarterly for compliance with the completion of therecertification comprehensive assessment. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur</p>	

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	<p>the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse promptly alerted the physician to changes in the patient's condition for 2 of 12 records reviewed (4 and 12) with the potential to affect all of the agency's active patients.</p> <p>Findings</p> <p>1. Clinical record #4, start of care (SOC) 10/21/10 and primary diagnosis of diabetes, included a plan of care for the certification period of 2/21/14 - 4/12/14 with orders for the skilled nurse to monitor foot care closely and to do skilled assessment and disease process management. At skilled nurse visits on 2/13/14 and 2/19/14 the skilled nurse documented changes in the patients condition that were not updated with the physician.</p> <p>a. A clinical record document titled "Skilled Nursing Note" with a date of 2/13/14 and signed by Employee J, Registered Nurse, stated, "Purplish feet ... burning and tingling [in legs]." The record failed to evidence the physician had been notified.</p> <p>b. A clinical record document titled "Skilled Nursing Note" with a date of 2/19/14 and time of 9:45 AM and signature of Employee J stated, "States ... feet feel cold and numb today. Purplish color." The record failed to evidence the physician had been notified.</p>	N000546	The Administrator/DON have conducted in-services with all nursing staff to address the regulations,policies and procedures on following the established plan of care, evaluating and re-evaluating the patient's on-going needs and notifying the physician in any change in patient condition and needs; the process of reporting changes and needs to the physician promptly. Travel charts have been established to include all necessary documents including the POC. 100% of the records have been audited with education provided to the nursing staff on deficiencies noted. Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is correctedand will not recur.	04/17/2014

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N000550	<p>c. On 3/14/14 at 2:30 PM, the administrator / director of nursing indicated the doctor had not been notified of the patient's complaint and change of condition."</p> <p>2. Clinical record #12, SOC 10/23/13 and primary diagnosis of diabetes, included a start of care assessment on 10/23/13 where the skilled nurse had documented the patient's pain level was a "6" on a numerical scale of "1 - 10." ("1" is the lowest and "10" is the highest).</p> <p>On 3/14/14 at 2:55 PM, Employee A indicated the pain level was not reported to the physician. 410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review and interview, the agency failed to ensure the home health aide care plan was updated in 2 of 8 records reviewed of patients receiving aide services (3 and 7) creating the potential to affect patients with aide services.</p> <p>Findings</p> <p>1. Clinical record #3, primary diagnosis of Alzheimer's Disease and Start of Care</p>	N000550	<p><b>Nursing staff re-educated on requirements related to home health aide services and supervision. 84% nursing staff no longer with agency. Nurses have been given both paper and electronic means of developing aide care plan. Patients with aide services will receive updated care plans. Administrator or designee will monitor 10% of charts weekly for aide supervision and presence of care</b></p>				

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NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 JOLIET ST STE 312 DYER, IN 46311		
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N000604	<p>(SOC)10/24/13, contained a plan of care for 12/23/13 - 2/20/14 with orders for home health aide visits 1 - 2 times a week for 9 weeks. The aide care plan had not been updated since 10/24/13. Aide visits were made on 2/3/14, 2/7/14, 2/10/14, 2/13/14, and 2/17/14.</p> <p>On 3/14/14 at 1:56 PM, Employee A, administrator / director of nursing, indicated the aide care plan had not been updated every 60 days.</p> <p>2. Clinical record #7, SOC 7/26/13 and primary diagnosis of diabetes, contained a plan of care for 12/21/13 - 3/22/14 with orders for skilled nursing once a week and for home health aide visits (the frequency and duration was not ordered). The aide care plan had not been updated since 7/26/13. Home health aide visits were made on 12/23/13, 12/29/13, 12/31/13, 1/4/14, 1/7/14, 1/14/14, 1/18/14, 1/21/14, 1/25/14, and 1/28/14.</p> <p>On 3/18/14 at 11 AM, Employee A indicated the aide care plan had not been updated since 7/26/13.</p> <p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.</p> <p>Based on observation , clinical record review, and interview, the agency failed to ensure the home health aide reported changes observed to the supervisory nurse for 1 of 1 observation of a home health aide (Employee</p>	N000604	<p><b>plan.Administrator will be responsible formonitoring these corrective actions and will be reviewed each quarterly qualitymeeting to ensure this deficiency does not recur.</b></p> <p>The Administrator and DONhave conducted in-services with all home health aides for the need to reportany changes in patient condition to the RN case manager upon discovery of</p>		

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N000606	<p>E) with the potential to affect all patients receiving home health aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 3/13/14 at 3:30 PM, Employee E, home health aide, was observed to give a partial bath to patient #6. The patient had two small open areas in the patient's groin area. After the bath, the caregiver at the home applied ammonium lactate lotion that had been ordered by the physician. The patient complained of pain when this topical medication was applied. This record failed to evidence the aide had reported the open areas to the nurse.</li> <li>On 3/14/14 at 4 PM, Employee E indicated not updating the nurse about the discomfort the patient had at the visit on 3/13/14 or the new open areas on the patient's groin area.</li> </ol> <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</p>		<p>that change and the required documentation. The aide involved with the cited incident has had additional education and counseling. The DON has in-service all nursing case managers on the need to inform the physician of any significant change in patient condition and follow up with any further orders related to that condition change.</p> <p>100% of the clinical records have been audited for compliance with notifying the physician of change in patient condition and needs. At the supervisory visits the communication logs will also be monitored for any documented change in condition.</p> <p>The DON will review all documentation to ensure that any change in condition is reported the physician.</p> <p>The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>	

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N000608	<p>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 and interview, the agency failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every 30 days in 1 of 8 records reviewed of patients (#5) that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled and home health aide services.</p> <p>Findings</p> <p>1. Clinical record #5 evidenced home health aide services had been provided 1- 2 times a week for 9 weeks during the certification period of 12/30/13 - 2/27/14 and skilled nurse had been provided 1 - 2 times a week for 9 weeks. The record evidenced that no supervisory visits had been provided from 12/30/13 - 2/27/14 by the registered nurse.</p> <p>2. On 3/14/14 at 3:20 PM, the administrator / director of nursing indicated the aide supervision had not occurred at the for the time period identified.</p> <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: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist,</p>	N000606	<p><b>Nurses were re-educated on the policyHome Health Aide Supervision. 84% of nursing no longer with agency . Nurses were re-educated on policy of aide careplan Administrator or designee will monitor10% of charts weekly for aide supervision. Administratorwill be responsible for monitoring these corrective actions and will bereviewed each quarterly quality meeting to ensurethis deficiency does not recur.</b></p>	04/17/2014

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	<p>chiropractor, podiatrist, or optometrist.</p> <p>(3) Drug, dietary, treatment, and activity orders.</p> <p>(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.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to maintain clinical records in accordance with its own policy in 3 of 12 records reviewed (1, 3, 4) creating the potential to affect all of the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 1/17/1 and primary diagnosis of Osteoarthritis, included a plan of care for the certification period of 1/17/14 - 3/17/14. There was no initial assessment in the record at this time. The initial assessment was found outside of the record on 3/14/14.</p> <p>On 3/14/14 at 2:35 PM, the administrator / director of nursing indicated the clinical record had missing documentation.</p> <p>2. Clinical record #3, primary diagnosis of Alzheimer's Disease and Start of Care 10/24/13, contained plans of care for 12/23/13 - 2/20/14 and 2/21/14 - 2/21/14. The record failed to evidence a recertification assessment when the record was reviewed on 3/12/14.</p>	N000608	<p><b>Administrator and designee have gone through all drawers and cabinets in agency and all medical records were placed in appropriate area/chart/file. All filing to be done in a timely manner and not to be placed in inappropriate areas. Administrator or designee to monitor cubicles two times weekly for filing and monitor that fax confirmations are attached to orders. Monitor that there is always a copy of documents in patients chart if awaiting a signature. Transition to Axxess to reduce filing. Administrator will be responsible for monitoring these corrective actions and will be reviewed each quarterly quality meeting to ensure this deficiency does not recur.</b></p>	04/17/2014			

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	<p>On 3/14/14 at 1:55 PM, the administrator / director of nursing indicated the recertification for 2/17/14 had not been present in the record and was found and placed in the record. This document should have been placed in the record in a timely manner.</p> <p>2. Clinical record #4, SOC 10/21/10 and primary diagnosis of diabetes, failed to evidence a start of care assessment and medication profile.</p> <p>On 3/14/14 at 2:20 PM, Employee J indicated the SOC assessment and medication profile were missing from the record.</p> <p>3. The agency policy titled "Clinical records / Medical Record Retention" and no effective date stated, " Clinical record [is] A confidential clinical record containing pertinent past and current findings in accordance with professional standards is maintained for every patient receiving home health services."</p>			