

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2015
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NAME OF PROVIDER OR SUPPLIER  ASSURED HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1947 HARDER CT STE B SCHERERVILLE, IN 46375
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G 000  Bldg. 00	<p>This visit was for a home health federal recertification survey. This was an extended survey.</p> <p>Survey date: February 3 - 10, 2015</p> <p>Facility #: 011121</p> <p>Medicaid vendor #: 200839240</p> <p>Surveyor: Ingrid Miller, PHNS, RN Tameka Warren, PHNS, RN</p> <p>Skilled unduplicated census: 155</p> <p>Assured Home Healthcare Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning February 10, 2015, - February 10, 2017, due to being found out of compliance with Conditions of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 484.30 Skilled Nursing Services; 484.52 Evaluation of the Agency's Program; and 484.55 Comprehensive Assessment of Patients.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p>	G 000		

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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G 121 Bldg. 00	<p>February 16, 2015</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, interview, and review of policy and procedures, the agency failed to ensure staff had provided services in accordance to their own infection control polices in 2 of 6 home visit observations with patients #3 and #8 creating the potential to affect any patients cared for by employee E, home health aide, and employee H, Registered Nurse.</p>	G 121	<p>The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the standard, 484.12(c), Compliance with Accepted Professional Standards and Principles, and agency policies on Infection Control, Hand Hygiene, Standard Precautions, and Bag Technique. The Administrator and Director of Nursing have also discussed with employees E and H individually about the home visit findings and observations, reviewing the standards and principles with agency policies. Both employees have verbalized understanding and have also performed a return demonstration during the discussion. The Director of Nursing has further in-serviced field staff on February 23rd, 2015</p>	02/23/2015

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	<p><b>Findings:</b></p> <p>1. Home visit observation made on 2/5/15 at 9:10 AM to patient #3 with employee H, Registered Nurse (RN).</p> <p>A. At 9:15 AM, the RN was observed taking the patient's blood pressure after which she returned the blood pressure cuff to her nursing bag without disinfecting it.</p> <p>B. At 9:30 AM, the RN was observed changing the patient's dressing to coccyx. The patient had stool present at the time of wound dressing change. RN cleaned stool off patient with baby wipes, laid soiled baby wipes on chuck under patient. When completed cleaning patient, rolled chuck under patient and dipped soiled gloved hand into Silvadene topical cream and applied to patient's coccyx, left open to air. Placed new chuck under patient and turned patient back over. Repositioned patient with help of family friend and removed gloves and applied new gloves without disinfecting hands.</p> <p>C. At 9:45 AM, the RN was observed changing the patient's dressing to G-tube stoma. The RN removed old dressing and with the same gloves used to remove the old dressing, the RN cleansed the site</p>		<p>on the standards and principles going over agency policies and procedures implemented for infection control, wound care management, and hand hygiene teaching with bag technique demonstration during the in-service. The Administrator, Director of Nursing, and Quality Assurance Nurse will be responsible for the maintenance and monitoring the compliance in accordance with policies and procedures implemented for control of communicable disease by requiring field employees perform a yearly return demonstration of bag technique and hand hygiene observing standard precautions.</p>	

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	<p>with normal saline and applied clean split gauze. The RN stated she was having difficulty using the paper tape with gloved hands. The roll of paper tape that had been handled with soiled gloves was returned to her zip lock bag of supplies, she then removed another roll of tape from the zip lock bag. The RN then removed her gloves and without disinfecting her hands continued to complete and finish applying the dressing to the patients G-tube site without gloves. She then placed the paper tape used to complete the dressing change back into the zip lock bag of supplies. She cleaned up her work area including the old dressing and used supplies without gloves on. She then returned her zip locked bag of supplies to her nursing bag without disinfecting them and without washing or disinfecting hands before placing supplies in nursing bag.</p> <p>D. Interview on 2/6/15 at 2:15 PM, the agency's administrator and Director of Nursing (DON) agreed the employee H, RN, should have disinfected hands between glove changes, gloves should have been worn for the duration of wound care, and supplies should have</p>			

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	<p>been disinfected before reinserting them in the nursing bag for care provided to Patient #3 during home visit.</p> <p>2. Home visit observation made on 2/6/15 at 10:20 AM to patient #8 with employee E, Home Health Aide (HHA).</p> <p>A. At 11:10 AM, after the patient's bath employee E, placed zip locked bags of supplies into nursing bag with gloves on that were used to bath the patient.</p> <p>B. Interview on 2/6/15 at 1:45 PM, the agency's administrator and DON agreed that the employee E, HHA, should have removed gloves and washed hands before placing supplies into nursing bag.</p> <p>3. The agencies policy titled "Hand Hygiene", dated May 2010, states, "Purpose: To prevent cross-contamination and home care-acquired infections ... 3. Hand decontamination using an alcohol-based hand rub should be performed ... G. After removing gloves ... ."</p> <p>4. The agencies policy titled "Standard Precautions ", dated May 2010, states, "Purpose: To reduce the risk of exposure to and transmission of infections when caring for patients ... 1. Gloves ... Gloves are to be worn when ... 1. There is actual</p>			

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G 144 Bldg. 00	<p>or potential contact with blood or other potentially infectious materials ... 11. Performing wound care ... C. Gloves are to be changed: 1. Between tasks and procedures on the same patient 2. During changing or cleaning an incontinent patient 3. After removing an old dressing ... "</p> <p>5. The agencies policy titled "Bag Technique", dated May 2010, states, "Purpose: To describe the procedure for maintaining a clean nursing bag and preventing cross contamination ... 5. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to bag... ."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on clinical record and agency</p>	G 144	The Administrator, Director of Nursing, and Quality Assurance Nurse have reviewed the	02/23/2015

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	<p>policy review and interview, the home health agency failed to maintain documentation in the clinical record or minutes of case conferences for 3 of 12 (3, 6, and 11) clinical records reviewed with the potential to affect all of the agency's 75 active patients.</p> <p>Findings:</p> <p>1. Clinical record number 6, start of care 4/17/15 and discharge of 10/10/15, included a plan of care established by the patient's physician for the certification period of 8/15/14 - 10/13/14. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record. Services provided to this patient were skilled nursing, home health aide, and occupational therapy.</p> <p>On 2/5/15 at 1:15 PM, the director of nursing indicated the lack of case conference / communication notes in the record.</p> <p>2. Clinical record number 11, start of care 8/9/14, included a plan of care established by the patient's physician for the certification period 1/7/14 - 2/4/15. The record failed to evidence minutes of case conferences or documentation of coordination of patient care. Services</p>		<p>standard, 484.14(g), Coordination of Patient Services, and agency policies on Scope of Services and Case Conference/Progress Summary. With the indication that the Director of Nursing has been educating the agency's staff during the survey, the Director of Nursing has further in-serviced agency staff on February 23, 2015 on the importance of the standard and agency policies in participation of case conferences and documentation of this in the clinical record. Case Conferences will be held at the start of care and at least every 60 days to review and discuss multidisciplinary cases and as needed if there is a change in the patient's status that requires a change in the patient's care plan. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions, to ensure this deficiency is corrected and will not recur. All findings will be reported to the Director of Nursing.</p>		

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	<p>provided to the patient were skilled nursing and home health aide services.</p> <p>On 2/9/15 at 1 PM, the administrator indicated she had written scratch notes somewhere but these were not in the clinical record at this time.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include coordination of services."</p> <p>4. The agency policy titled "Case conference / Progress Summary" with a revised date of May 2010 stated, "Case conferences will be held at the start of care and at least every 60 days to review and discuss multidisciplinary cases."</p> <p>5. On 2/9/15 at 2:35 PM, the director of nursing indicated care communication notes were missing from the clinical records and he was educating the staff on including care communication notes in the records.</p> <p>6. Clinical record #3 (SOC 1/12/15, Certification Period 1/12/15-3/12/15) failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical</p>						

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G 156 Bldg. 00	<p>record. Services provided to this patient were skilled nursing and home health aide.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on observation, clinical record and agency policy and procedure review, and interview, it was determined the agency failed to ensure plans of care were ordered by and reviewed by physicians to continue home care services and followed by the registered nurse and home health aides providing services for 7 of 12 records reviewed (See G 158); failed to ensure the plan of care was signed by the PCP and included all required elements for 3 of 12 records reviewed (see G 159); and failed to ensure physician's verbal and telephone orders were signed by the physician within the time frame stated in the agency's policy for 2 of 12 records reviewed.</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the</p>	G 156	The Administrator, Director of Nursing, and Quality Assurance Nurse have reviewed the condition, 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision. Further reviewing the clinical records that have been observed and reviewed during the survey. The agency will take immediate actions for the following: to ensure plans of care are ordered by and reviewed by physicians to continue home care services and followed by the registered nurse and home health aides providing services; to ensure the plan of care is signed by the PCP and include all required elements; and to ensure physician's verbal and telephone orders were signed by the physician within the time frame stated in the agency's policy. Education of agency staff was immediate starting with office staff to make awareness of the condition and findings during the survey. The Quality Assurance	02/11/2015

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G 158 Bldg. 00	<p>Condition of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, policy review, observation, and interview, the agency failed to ensure plans of care were ordered by and reviewed by physicians to continue home care services and followed by the registered nurse and home health aides providing services for 7 of 12 records reviewed (2, 3, 4, 5, 6, 9, and 12).</p> <p>Findings</p> <p>1. Clinical record #5, start of care (SOC) 10/14/15 and a diagnosis of dementia, included a plan of care for the</p>	G 158	<p>Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions, to ensure this deficiency is corrected and will not recur. All findings will be reported to the Director of Nursing and/or Administrator. The Administrator, Director of Nursing, and Quality Assurance Nurse are responsible for ensuring this deficiency is corrected and to maintain compliance.</p> <p>The Administrator, Director of Nursing, and Quality Assurance Nurse have reviewed the standard, 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision that care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatric medicine. Further reviewing agency policies on Scope of Services, Ongoing Assessments, and the Home Health Aide Job Description. The Administrator and Director of Nursing have further discussed with those employees individually that were directly associated with clinical record findings during the survey reviewing the standard</p>	03/06/2015

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	<p>certification period of 12/29/14 - 2/26/15. This plan of care included an extra visit made by the HHA on 1/6/15. HHA visits were ordered on the plan of care for 1 visit a week x 5 weeks. There were visits on 1/4/15 and 1/7/15 with HHA.</p> <p>On 2/4/15 at 3:50 PM, the administrator stated, "I forgot I told her to make an extra visit.</p> <p>2. At a home visit observation on 2/5/15 at 10 AM, Employee G, Registered Nurse, failed to complete a total physical assessment with patient #6. The patient's feet were not examined. No pedal pulses were assessed. The skilled nurse filled the patient's medication reminder box for a week. The patient did not fill the medication box.</p> <p>a. Clinical record #6, the active record of patient #6 with a principal diagnosis of rheumatoid arthritis and SOC date of 1/12/14, included a plan of care for the certification period of 1/12/15 - 3/12/15. This plan of care stated, "Skilled nurse to assess patient's physical and mental status ... SN to focus physical assessment to cardiovascular status noting baseline vital signs and changes over episode and s/s [signs and symptoms] of edema ... SN[skilled nursing] to assess patient filling</p>		<p>and agency policies to ensure this deficiency may not recur with those employees as care services of the agency are to be provided in accordance with the patient's plan of care that is established and reviewed by the physician. Clinical record #9, SOC 12/13/14, certification period 12/13/14-2/10/15, had no visit observed during the week of 12/14/15 – 12/20/15 during survey, after discussing with clinical record #9's nurse, there was a missed visit for that week (See Attachment 1). Clinical record #12, SOC 5/8/14, multiple certification periods not signed within time frame, it has been discussed during the survey that these plans of care have been sent and notified to the physician, but not received back with physician signature in a timely. Agency has attempted multiple times to check for status of patient's plan of care with physician's signature, and physician's staff repeatedly replied, "Documents are in process." Agency is to work closely and follow up with physician's office to obtain signed plans of care (See Attachment 2). Clinical record #2, SOC 1/12/15, certification period 1/12/15-3/12/15, Employee B, Director of Nursing, has reviewed the patient's plan of care and need for patient's physical assessment, employee has verbalized understanding.</p>	

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	<p>medication box to determine if patient is preparing correctly."</p> <p>b. On 2/5/15 at 10:30 AM, Employee G indicated not assessing the patient's feet or the patient's pedal pulses on the feet or checking for edema on the lower extremities at the visit. She also indicated filling the patient's medication weekly reminder box for the next week.</p> <p>c. On 2/9/15 at 3:50 PM, the administrator was asked if Employee G followed the plan of care with the lack of assessment of the patient's feet at this visit on 2/5/15 at 10 AM. The administrator did not answer and shrugged her shoulders.</p> <p>d. This was a previous discharged record for Clinical record #6. Clinical record #6, start of care 4/17/14 and discharge of 10/10/14, included a plan of care for the certification period of 8/15/14 - 10/13/14. This plan of care was not signed by the physician until 10/13/14. Nursing visits were made on 10/2/14 and 10/10/14. home health aide (HHA) visits were made on 8/15/14, 8/19/14, 8/22/14, 8/26/14, 8/29/14, 9/2//14, 9/5/14, 9/9/14, 9/12/14, 9/16/14, 9/19/14, 9/23/14, 9/26/14, 9/29/14, 10/3/14, 10/6/14, 10/10/14. occupational Therapy (OT) visits were made on</p>		<p>Clinical record #3, 11/07/14, certification period 1/6/15-3/6/15, the Administrator has discussed with Employee H of the standard and agency policies in regards with the patient's plan of care and home visit observation during survey, and Employee H has verbalized understanding. Clinical record #4, SOC 10/30/14, certification period 12/29/14-2/26/15: After review of the plan of care for clinical record #4, the Director of Nursing has discussed an issue during the survey concerning the form of the Home Health Aide Care Plan as the form was created by the agency's software vendor. Where the form only has three columns, "QV", "QW", and "NA". The skilled nurse filling out the form may check "QV", which would be interpreted as "every visit" rather than "as needed". So due to the layout of the form as created from the software vendor the skilled nurse may document differently than what would be interpreted. Therefore the findings during the home visit were observed and interpreted in that manner. The Director of Nursing expressed this concern, the need of an "as needed" column, with the agency's software vendor and the software vendor is currently developing a form that would have an "as needed" column on the Home Health Aide Care Plan as attached with a "PR" column</p>	

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	<p>8/15/14, 8/18/14, 8/22/14, 8/27/14, 8/29/14, 9/5/14, and 9/6/14.</p> <p>e. On 2/5/15 at 4:45 PM, the administrator indicated the plan of care was not signed in a timely manner.</p> <p>3. Clinical record # 9, start of care 12/13/14 and diagnosis of post traumatic seizures, included a plan of care for the certification period of 12/13/14 - 2/10/15 with skilled nursing ordered 1 times a week X 9 weeks. There was no visit for the week of 12 / 14 /15 - 12/20/14.</p> <p>On 2/3/15 at 2:15 PM, the administrator did not respond to why there was no nursing visit the week of 12/14/15 - 12/20/14 when asked why the nursing visit had not occurred.</p> <p>4. Clinical record # 12, start of care 5/8/14 and diagnosis of open wound of breast, included a plans of care that were not signed in a timely manner by the physician.</p> <p>a. The clinical record included a plan of care for the certification period of 7/7/14 - 9/4/14. This plan of care was not signed by the physician until 8/31/14. A recertification visit occurred with the RN on 9/3/14.</p>		(See Attachment 3). Clinical record #8, SOC 9/2/14, certification period 12/31/14-2/28/15: After review of the plan of care for clinical record #8, the Director of Nursing reviewed the patient's plan of care and Home Health Aide Job Description with the Employee E, employee has verbalized understanding of the standard and the agency's policy. The Administrator, Director of Nursing, and Quality Assurance Nurse will in-service agency staff on March 6, 2015 that care services are to follow a written plan of care established, reviewed, and signed by a physician in accordance with the standard and agency's policies. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions, to ensure this deficiency is corrected and will not recur. All findings will be reported to the Director of Nursing and is responsible that this deficiency is corrected and compliance maintained.				

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	<p>b. The clinical record included a plan of care for the certification period of 9/5/14 - 11/3/14. This plan of care was not signed by the physician until 2/4/15. Another physician, not the attending physician, had signed this plan of care. A recertification visit with the RN occurred on 10/31/14. Other SN visits occurred on 10/2/14, 10/7/14, 10/25/14,</p> <p>c. The clinical record included a plan of care for the certification period of 11/4/14 - 1/2/15. This plan of care was not signed by the physician. The skilled nurse visited on 12/12/14, 12/16/14, 12/20/14, 12/26/14, 1/2/15. The home health aide visited on 12/24/14, 12/30/14, 12/31/14, 1/2/15.</p> <p>d. The clinical record included a plan of care for the certification period of 1/3/15 - 3/3/15. Skilled nurse visits had been made on 1/5/15, 1/12/15, 1/19/15, 1/27/15. HHA visits were made on 1/6/15, 1/7/15, 1/13/15, 1/14/15, 1/20/15, 1/21/15, 1/27/15, and 1/28/15.</p> <p>e. On 2/9/15 at 3:50 PM, the administrator indicated the plans of care had not been signed within the agency policy.</p> <p>5. The agency policy titled "Scope of Services" with a revised date of May</p>			

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	<p>2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse."</p> <p>6. Home visit observation made on 2/4/15 at 4:00 PM to patient #2 with Employee B, Director of Nursing. During this visit the patient's pedal pulse was not assessed and the patient's weight was not taken.</p> <p>A. Clinical Record #2's (SOC 1/12/15, Certification Period 1/12/15-3/12/15), included a plan of care that states, " ... SN is to focus physical assessment to cardiovascular status ... SN to perform weekly weight ... ". No weights were recorded in the patients chart during SN visits for the duration of service.</p> <p>B. Interview on 2/9/2015 at 2:55 PM, the Administrator and DON agreed that patient #2's weight should have been taken at the home visit observation and weekly at previous SN visits and pedal pulse should have been assessed as part of the total physical and focused cardiovascular assessment.</p> <p>7. Home visit observation made on 2/5/15 at 9:30 AM to patient #3 (SOC</p>			

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	<p>11/7/14, Certification Period 1/6/15-3/6/15) with employee H, Registered Nurse. During this visit the RN did not cleanse the wound to the patient's lower back with normal saline, only cleansed the area with baby wipes that were being used to remove stool from patient.</p> <p>A. The patient's plan of care states, " ... SN to perform/instruct on wound care as follows: Cleanse stage 1 pressure ulcer to lower back with 0.9% NS ... "</p> <p>B. The patient's plan of care states, " ... SN to inform physician if ... symptomatic heart rate greater than 100 or less than 60 beats/min ... ." On SN visit notes of 1/22/15 pulse 59, 1/15/15 pulse 57, 1/9/15 pulse 59, the physician was not informed of the out of range heart rates.</p> <p>C. Interview on 2/6/2015 at 2:15 PM, the Administrator and DON agreed that the RN, employee H, should have followed the plan of care by cleaning the wound to patient #3's lower back with 0.9% NS.</p> <p>D. Interview on 2/9/2015 at 2:45 PM, The Administrator and DON agreed that the RN, employee H, should have</p>			

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	<p>followed the plan of care by informing the physician of the patients out of range heart rates as stated in the plan of care.</p> <p>8. Clinical Record #4 (SOC 9/2/14, Certification Period 12/31/14-2/28/15), included a plan of care that states, " ... SN to perform weekly weight ... ." No weights were recorded in the patients chart during SN visits for the duration of service.</p> <p>Clinical Record #4 included a plan of care that states, " ... SN to perform weekly weight ... ." No weights were recorded in the patients chart during SN visits for the duration of service.</p> <p>9. The agency's policy titled "Ongoing Assessments", dated May 2010, states, "Purpose: To provide guidelines for assessments of patients during ongoing care ... 2. Using the standards of care identified by the organization, the clinician will reassess the patient for: ... B. Weight (once each week, if indicated by disease process) ... ."</p> <p>Regarding following the plan of care</p> <p>10. During a home visit observation on 2/5/15 at 11:00 AM to patient #4 with employee C, Home Health Aide, the aide was observed giving the patient a bath, pericare, taking vitals, skin care, nail</p>			

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	<p>care, and assist with dressing which did not include all care listed on the aide assignment sheet.</p> <p>11. Clinical Record Review on 2/6/15 at 1:58 PM of patient #4's clinical record (SOC 10/30/14, Certification Period 12/29/14-2/26/15), The plan of care states, " ... HA to assist with ADL's &amp; IADL's per HHA care plan ... ." All Aide visit notes completed by employee C in the patients clinical record were not completed as assigned on the Aide assignment sheet.</p> <p>A. Interview on 2/6/15 at 2:05 PM, the agency's administrator agreed that employee C, HHA should follow the aide assignment sheet.</p> <p>12. Home visit observation made on 2/6/15 at 10:30 AM to patient #8, with employee E, Home Health Aide, was observed giving the patient a bath, pericare, taking vitals, skin care, shampoo, hair care, nail care, side of bed dangle, and assist with dressing, which did not include all care listed on the aide assignment sheet.</p> <p>13. Clinical Record Review on 2/6/15 at 12:45 PM of patient #8's clinical record (SOC 9/2/14, Certification Period 12/31/14-2/28/15), the plan of care states,</p>			

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	<p>" ... HA to assist with ADL's &amp; IADL's per HHA care plan ... ." All Aide visit notes completed by employee E in the patients clinical record were not completed as assigned on the Aide assignment sheet.</p> <p>A. Interview on 2/6/15 at 1:45 PM, the agency's administrator agreed that employee E, HHA should follow the aide assignment sheet.</p> <p>14. The agencies policy titled "Home Health VI", dated May 2010, states, "Job Title/Position: Certified home Health Aide ... Job Description Summary ... The home health aide is responsible for observing patients, reporting these observations and care performed ... 1. Providing personal care including: ... C. Oral hygiene D. Shampoos E. Changing bed linen ... I. Keeping patients living area clean and orderly, as appropriate 2. Planning and preparing nutritious meals. 3. Assisting in feeding the patient, if necessary ... 5. Assisting in ambulation and exercise according to the plan of care. 6. Performing range of motion ... ."</p>			

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G 159 Bldg. 00	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on home visit observation, policy and clinical record review, and interview, the agency failed to ensure the plan of care was signed by the primary care physician (PCP) and included all required elements for 4 of 12 records reviewed (#1, #6, #11, #12) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record # 1, start of care 12/16/14 and diagnosis of unspecified hypertensive heart disease without heart failure, included a plan of care for the certification period of 12/16/14 - 2/13/15. This plan of care failed to include the</p>	G 159	<p>The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the standard, 484.18(a), Plan of Care, and company policies on Scope of Services, Admission Criteria and Process, Care Planning Process, Physician Participation in Plan of Care, and Verification of Physician Orders. The Administrator and Director of Nursing have individually discussed the findings with the skilled nurse employee for patient #1, and has revised the plan of care with the physician's order and signature to include the assessment of patient's pacemaker and any electronic device that may be used for monitoring (See attachment 4). The Administrator has notified the physicians' offices and their staff</p>	03/06/2015

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	<p>patient's pacemaker and its location on the patient's left chest and the presence of an electronic medical monitoring device to monitor the pacemaker in the home.</p> <p>a. On 2/4/15 at 10 AM, patient #1 indicated having a pacemaker on the left side of the chest and a medical monitoring device to electronically evaluate the pacemaker in the home. Patient #1 indicated having these the pacemaker and electronic monitoring device since March of 2014.</p> <p>b. On 2/4/15 at 10:05 AM, a cardiac monitoring device for the patient's pacemaker electronic device was noted by the bedside of patient #1.</p> <p>c. On 12/4/14 at 4:10 PM, the administrator indicated the plan of care failed to show the patient had a pacemaker or a electronic monitoring device for the pacemaker present in the home.</p> <p>2. Clinical record #6, start of care 4/17/14 and discharge of 10/10/14, included a plan of care for the certification period of 8/15/14 - 10/13/14. This plan of care was not signed by the physician until 10/13/14. Nursing visits were made on 10/2/14 and 10/10/14. Home health aide (HHA) visits were</p>		<p>to discuss the resolution of having physician signatures and received back to the agency in a timely manner. After discussion, orders have been received back with physician's signature (See Attachment 2). Case conference notes and order are attached for clinical record #11 (See Attachment 6). The Administrator and Director of Nursing and Quality Assurance Nurse will in-service and educate all staff on March 6, 2015 on the importance of physical assessments and documenting all equipment and supplies in accordance to the patient's plan of care, obtaining physician signature orders in timely manner contacting and following up physicians' office staff and assistants. Th Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions and to ensure this deficiency is corrected and will not recur, and report all findings to the Director of Nursing and is responsible that this deficiency is corrected and compliance maintained.</p>	

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	<p>made on 8/15/14, 8/19/14, 8/22/14, 8/26/14, 8/29/14, 9/2//14, 9/5/14, 9/9/14, 9/12/14, 9/16/14, 9/19/14, 9/23/14, 9/26/14, 9/29/14, 10/3/14, 10/6/14, 10/10/14. OT visits were made on 8/15/14, 8/18/14, 8/22/14, 8/27/14, 8/29/14, 9/5/14, and 9/6/14.</p> <p>On 2/5/15 at 4:45 PM, the administrator indicated the plan of care was not signed in a timely manner.</p> <p>2. Clinical record #11, start of care date 8/9/14 and a primary diagnosis of unspecified hypertensive heart disease with heart failure, included a plan of care for the certification period of 12/27/14 - 2/4/15. The patient was still on service and did not have a recertification assessment for the next recertification period completed. There was no plan of care for the new certification period.</p> <p>On 2/10/15 at 12:35 PM, the administrator indicated the patient was still on service and did not have a current plan of care.</p> <p>3. Clinical record # 12, start of care 5/8/14 and diagnosis of open wound of breast, included a plans of care that were not signed in a timely manner by the physician.</p>						

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	<p>a. The clinical record included a plan of care for the certification period of 7/7/14 - 9/4/14. This plan of care was not signed by the physician until 8/31/14. A recertification visit occurred with the registered nurse (RN) on 9/3/14.</p> <p>b. The clinical record included a plan of care for the certification period of 9/5/14 - 11/3/14. This plan of care was not signed by the physician until 2/4/15. Another physician, not the attending physician, had signed this plan of care. A recertification visit with the RN occurred on 10/31/14. Other skilled nurse (SN) visits occurred on 10/2/14, 10/7/14, 10/25/14,</p> <p>c. The clinical record included a plan of care for the certification period of 11/4/14 - 1/2/15. This plan of care was not signed by the physician. The skilled nurse visited on 12/12/14, 12/16/14, 12/20/14, 12/26/14, 1/2/15. The home health aide visited on 12/24/14, 12/30/14, 12/31/14, 1/2/15.</p> <p>d. On 2/9/15 at 3:50 PM, the administrator indicated the plans of care had not been signed timely.</p> <p>4. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing</p>			

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	<p>services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include: initial and ongoing assessments of the patient's needs, including OASIS assessments at appropriate points in time ... initiating the plan of care and revising as necessary ... physician services are provided by the licensed Doctor of Medicine, Osteopathy, and Podiatrist and include ... developing and / or authorizing the plan of care ... submitting signed orders for plans of care and changes in accordance with required time frames."</p> <p>5. The agency policy titled "Admission Criteria and Process" with a revised date of May 2010 stated, "The patient must be under the care of a physician. The patient's physician ... must order and approve the provision of any service ... The initial assessment must be performed within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician."</p> <p>6. The agency policy titled "Care Planning Process" with a revised date of May 2010 stated, "A written plan of care will be initiated within 5 days of start of care and updated at least every 60 days or as the patient's condition warrants ... the clinical plan of care includes ... supplies</p>			

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	<p>and equipment required ... at the time of the initial assessment, the clinician ... will develop the patient plan of care based upon the patient's identified needs and will review it with the patient and family / caregiver ... all clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, including but not limited to ... A. individualized patient needs and resultant problems related to care, functional status, and family / caregiver support system ... patient treatment choices ... based on the assessment and conclusions, the plan of care will include, but will not be limited to A. identified patient problems and needs ... equipment and supplies ... the plan of care will be based upon the physician's ... orders and will encompass the equipment, supplies, and services required to meet the patient's needs ... the clinicians will be responsible to revise the plan of care or update the plan at least every 60 days."</p> <p>7 The agency policy titled "Physician Participation in plan of care" with a revised date of May 2010 stated, "A physician will direct the care of every home health care patient admitted for service ... The attending physician will participate in the care planning process by initiating, reviewing and revising therapeutic and diagnostic orders ... the</p>			

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	<p>attending physician's verbal certification will be obtained at the time the plan of care is established. 3. The attending physician will certify the need for the home health care services by signing the plan of care / treatment within 30 days of the start of care. 4. The attending physician's recertification will be obtained in intervals of at least every 60 days when the patient's plan of care is reviewed, the patient is recertified, and more often, if warranted."</p> <p>8. The agency policy titled "Verification of Physician Orders" with a revised date of May 2010 stated, "to ensure that accurate physician ... orders are obtained in accordance with applicable law and regulation ... Orders will be documented on a form provided by Assured Home Healthcare, inc. dated and signed by the professional receiving the order."</p>			

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G 166 Bldg. 00	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure physician's verbal and telephone orders were signed by the physician within the time frame stated in the agency's policy for 2 of 12 records reviewed with the potential to affect all the agency's patients. (#6 and #12)</p> <p>Findings include:</p> <p>1. Clinical record #6 contained physician orders that were not signed within 30 days.</p> <p>a. A physician verbal order dated 7/31/14 that stated, "O.T. to evaluate and treat." was signed by the RN on 7/31/14 and not signed by the physician until 1/15/15.</p>	G 166	The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the standard, 484.18(c), Conformance with Physician Orders, and company policy on Verification of Physician Orders. The Administrator has notified the physicians' offices during the survey and their staff to discuss the resolution and importance of having physician signatures and received back to the agency in a timely manner. After discussion, orders have been received back with physician's signature (See Attachment 2). The Administrator and Director of Nursing and Quality Assurance Nurse have taken immediate action to educate all staff on the importance of obtaining physician signature orders in a timely manner contacting and following up with physicians' office staff and their assistants. The Quality	02/11/2015

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	<p>b. A physician verbal order dated 8/14/14 that stated, "Recertification of home health care services with Assured Home Healthcare, inc. for continued assessment, teachings, and interventions of medications, diet, and treatment in the home. Discipline visit frequency as follows SN 1 wk 7, HHA 1 wk 1, 2 wk 6, OT frequency 1 w 1, 2 w 3." This order was signed by the RN on 8/14/14 and not signed by the physician until 1/15/15.</p> <p>c. A physician verbal order dated 10/10/14 that stated, "Discharge from Home Health care Services, goals achieved. " was signed by the RN on 10/10/14 and not received from the physician until 11/17/14. There was no date noted with the physician's signature.</p> <p>d. On 2/5/15 at 4:45 PM, the administrator indicated the verbal orders were not signed as required by policy.</p> <p>2. Clinical record # 12, start of care 5/8/14 and diagnosis of open wound of breast, included verbal orders that were not signed by the physician or not signed within 30 days per agency policy.</p> <p>A. A Physical Therapy evaluation visit note, dated 11/17/14, evidenced orders for physical therapy visits two</p>		Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions and to ensure this deficiency is corrected and will not recur as physician orders with their signature are received back to the agency, and to report all findings to the Director of Nursing and/or Administrator whom are responsible that the deficiency has been corrected and compliance maintained.	

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	<p>times a week for 4 weeks. The order failed to evidence a physician signature.</p> <p>B. A clinical record document titled "Physician Order" and with a date of 7/3/14 stated, "Recertification of home health care services with Assured Home Healthcare, Inc. for continued assessment, teaching, and interventions of medications, diet, and treatments in the home. Discipline visit frequency as follows: SN 1 wk 8, HHA 2wk8." This document was signed by another physician, not the patient's attending physician, on 1/20/15 and received by the agency on 2/9/15.</p> <p>C. A clinical record document titled "Physician Order" and with a date of 1/2/15 stated, "Recertification of home health care services with Assured Home Healthcare, Inc. from day 1 recert 1/3/15 - 3/3/15 for continued assessment, teaching, and interventions of medications, diet, and treatments in the home. Discipline frequency as follows: SN 1 wk 8 start week of 1/4/15 and HHA 2 Wk 8 start week of 1/4/15. This order was not signed by the physician.</p> <p>D. A clinical record document titled "Physician Order" and with a date of 11/18/14 stated, "Cleanse patient's stage II pressure ulcer on coccyx with 0.9</p>			

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	<p>% normal saline and sterile gauze, apply hydrocolloidal ... wound dressing, changing every SN visit and as needed teaching family and caregiver of wound care and treatment." This order was signed by the RN on 11/18/14. It was not signed by the physician.</p> <p>E. A clinical record document titled "Physician Order" and with a date of 5/12/14 stated, "SN may do venipuncture for CMP, CBC with diff, Lipid panel, T 4, TSH this week." This order was signed by the Registered nurse on 5/12/14 and not signed by the physician.</p> <p>3. The agency policy titled "Verification of Physician Orders" with a revised date of May 2010 stated, "To ensure that accurate physician ... orders are obtained in accordance with applicable law and regulation ... Orders will be documented on a form provided by Assured Home Healthcare, inc. dated and signed by the professional receiving the order."</p>			

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G 168  Bldg. 00	<p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record review, policy review, observation, and interview, it was determined the agency failed to ensure skilled nursing services followed the plan of care for 4 of 12 records reviewed (See G 170), failed to ensure the registered nurse had completed the initial / comprehensive assessment for 2 of 12 records reviewed (See G 171), and failed to ensure the registered nurse reevaluated the patient's needs at time of recertification for 2 of 6 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days (See G 172).</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition 484.30 Skilled Nursing Service.</p>	G 168	The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the condition, 484.30, Skilled Nursing Services, and the clinical records that were observed from the survey. And it has been concluded that in order to make sure this condition has been met is to do an audit review of 10% of the clinical records quarterly through 02-2016 by the Quality Assurance Nurse and QA staff that skilled nursing services have to follow the plan of care, ensure the RN has completed the initial/comprehensive assessment, and to ensure the RN re-evaluates the patient's needs at the time of recertification; reporting all findings the Director of Nursing and/or Administrator. In-service is to be provided to the skilled nursing staff by the Administrator, Director of Nursing, and Quality Assurance Nurse on 03/06/2015 to ensure this condition will be met.	03/06/2015			
G 170  Bldg. 00	<p>484.30 SKILLED NURSING SERVICES</p> <p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review, policy review, observation, and interview, the</p>	G 170	The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the standard, 484.30, Skilled Nursing	03/06/2015			

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	<p>agency failed to ensure skilled nursing services followed the plan of care for 4 of 12 records reviewed (2, 3, 4, and 9 ).</p> <p>Findings</p> <p>1. At a home visit observation on 2/5/15 at 10 AM, Employee G, Registered Nurse, failed to complete a total physical assessment with patient #6. The patient's feet were not examined. No pedal pulses were assessed. The skilled nurse filled the patient's medication reminder box for a week. The patient did not fill the medication box.</p> <p style="padding-left: 40px;">a. Clinical record #6, the active record of patient #6 with a principal diagnosis of rheumatoid arthritis and SOC date of 1/12/14, included a plan of care for the certification period of 1/12/15 - 3/12/15. This plan of care stated, "Skilled nurse to assess patient's physical and mental status ... SN to focus physical assessment to cardiovascular status noting baseline vital signs and changes over episode and s/s [signs and symptoms] of edema ... SN [skilled nursing] to assess patient filling medication box to determine if patient is preparing correctly."</p> <p style="padding-left: 40px;">b. On 2/5/15 at 10:30 AM, Employee G indicated not assessing the patient's</p>		<p>Services that the home health agency furnishes skilled nursing services in accordance with the plan of care, and has also reviewed company policies on Scope of Services and Ongoing Assessments. The Administrator and Director of Nursing have individually discussed the findings observed during the home visit with Employee G reviewing the standard and agency policies, also going over the patient's physical assessment and importance of following the plan of care. Employee G has verbalized understanding. Clinical record #9, SOC 12/13/14, certification period 12/13/14 -2/10/15, had no visit observed during the week of 12/14/15 – 12/20/15 during survey, after discussing with clinical record #9's nurse, there was a missed visit for that week (See Attachment 1). Clinical record #2, SOC 1/12/15, certification period 1/12/15-3/12/15, Employee B, Director of Nursing, has reviewed the patient's plan of care and need for patient's physical assessment, employee has verbalized understanding. Clinical record #3, 11/07/14, certification period 1/6/15-3/6/15, the Administrator has discussed with Employee H of the standard and agency policies in regards with the patient's plan of care and home visit observation during survey, and Employee H has verbalized understanding. The</p>				

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	<p>feet or the patient's pedal pulses on the feet or checking for edema on the lower extremities at the visit. She also indicated filling the patient's medication weekly reminder box for the next week.</p> <p>c. On 2/9/15 at 3:50 PM, the administrator was asked if Employee G followed the plan of care with the lack of assessment of the patient's feet at this visit on 2/5/15 at 10 AM. The administrator did not answer and shrugged her shoulders.</p> <p>2. Clinical record # 9, start of care 12/13/14 and diagnosis of post traumatic seizures, included a plan of care for the certification period of 12/13/14 - 2/10/15 with skilled nursing ordered 1 times a week X 9 weeks. There was no visit for the week of 12 / 14 /15 - 12/20/14.</p> <p>On 2/3/15 at 2:15 PM, the administrator did not respond to why there was no nursing visit the week of 12/14/15 - 12/20/14 when asked why the nursing visit had not occurred.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse."</p>		<p>Administrator, Director of Nursing, and Quality Assurance Nurse are to in-service on March 06, 2015 to the skilled nursing staff to ensure that skilled nursing services are to be followed in accordance with the patient's plan of care. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions and to ensure this deficiency is corrected and will not recur, and to report all findings to the Director of Nursing and/or Administrator whom are responsible that the deficiency has been corrected and compliance maintained.</p>	

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	<p>4. Home visit observation made on 2/4/15 at 4:00 PM to patient #2 with Employee B, Director of Nursing. During this visit the patient's pedal pulse was not assessed and the patient's weight was not taken.</p> <p>A. Clinical Record #2's (SOC 1/12/15, Certification Period 1/12/15-3/12/15), included a plan of care that states, "... SN is to focus physical assessment to cardiovascular status ... SN to perform weekly weight ... ". No weights were recorded in the patients chart during SN visits for the duration of service.</p> <p>B. Interview on 2/9/2015 at 2:55 PM, the Administrator and DON agreed that patient #2's weight should have been taken at the home visit observation and weekly at previous SN visits and pedal pulse should have been assessed as part of the total physical and focused cardiovascular assessment.</p> <p>5. Home visit observation made on 2/5/15 at 9:30 AM to patient #3 (SOC 11/7/14, Certification Period 1/6/15-3/6/15) with employee H, Registered Nurse. During this visit the RN did not cleanse the wound to the</p>			

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	<p>patient's lower back with normal saline, only cleansed the area with baby wipes that were being used to remove stool from patient.</p> <p>A. The patient's plan of care states, "... SN to perform/instruct on wound care as follows: Cleanse stage 1 pressure ulcer to lower back with 0.9% NS ... "</p> <p>B. The patient's plan of care states, "... SN to inform physician if ... symptomatic heart rate greater than 100 or less than 60 beats/min ... ." On SN visit notes of 1/22/15 pulse 59, 1/15/15 pulse 57, 1/9/15 pulse 59, the physician was not informed of the out of range heart rates.</p> <p>C. Interview on 2/6/2015 at 2:15 PM, the Administrator and DON agreed that the RN, employee H, should have followed the plan of care by cleaning the wound to patient #3's lower back with 0.9% NS.</p> <p>D. Interview on 2/9/2015 at 2:45 PM, The Administrator and DON agreed that the RN, employee H, should have followed the plan of care by informing the physician of the patients out of range heart rates as stated in the plan of care.</p> <p>6. Clinical Record #4 (SOC 9/2/14,</p>			

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G 171 Bldg. 00	<p>Certification Period 12/31/14-2/28/15), included a plan of care that states, " ... SN to perform weekly weight ... ." No weights were recorded in the patient's chart during SN visits for the duration of service.</p> <p>Clinical Record #4 included a plan of care that states, " ... SN to perform weekly weight ... ." No weights were recorded in the patients chart during SN visits for the duration of service.</p> <p>7. The agency's policy titled "Ongoing Assessments", dated May 2010, states, "Purpose: To provide guidelines for assessments of patients during ongoing care ... 2. Using the standards of care identified by the organization, the clinician will reassess the patient for: ... B. Weight (once each week, if indicated by disease process) ... ."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit.</p>			

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	<p>Based on home visit observation, policy and clinical record review, and interview, the agency failed to ensure the registered nurse had completed the initial / comprehensive assessment for 2 of 12 records reviewed (#1 and #9).</p> <p>Findings</p> <p>1. Clinical record # 1, start of care 12/16/14 and diagnosis of unspecified hypertensive heart disease without heart failure, evidenced an initial / comprehensive assessment was completed on 12/16/14 that lacked a physical assessment of the location of the pacemaker on the patient and lacked documentation concerning a medical monitoring device for the electronic monitoring of the pacemaker was present in the home at the bedside of the patient. Employee R, Registered Nurse, had completed this assessment on 12/16/14.</p> <p>a. On 2/4/15 at 10 AM, patient #1 indicated having a pacemaker on the left side of the chest and a medical monitoring device to electronically evaluate the pacemaker in the home. Patient #1 indicated having the pacemaker and electronic monitoring device since March of 2014.</p> <p>b. On 2/4/15 at 10:05 AM, an</p>	G 171	<p>The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the standard, 484.30(a), Duties of the Registered Nurse that the registered nurse makes the initial evaluation visit, and has also reviewed the company policies on Initial and Comprehensive Assessment. The Administrator and Director of Nursing have individually discussed the findings with the skilled nurse employee for patient #1, and has revised the plan of care with the physician's order and signature to now include the assessment of patient's pacemaker and any electronic device that may be used for monitoring (See Attachment 4). Further in-service to the skilled nursing staff was given by the Administrator, Director of Nursing, and Quality Assurance Nurse on March 06, 2015 going over the condition, company policies, and physical assessments. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions and to ensure this deficiency is corrected and will not recur, and to report all findings to the Director of Nursing and/or Administrator whom are responsible that the deficiency has been corrected and compliance maintained.</p>	03/06/2015	

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	<p>cardiac monitoring device for the patient's pacemaker electronic device was noted by the bedside of patient #1.</p> <p>c. On 2/4/15 at 4:10 PM, the administrator indicated the comprehensive assessment failed to show the patient had a pacemaker or a electronic monitoring device for the pacemaker present in the home.</p> <p>2. Clinical record # 9, start of care 12/13/14 and diagnosis of post traumatic seizures, evidenced an initial start of care / comprehensive assessment was completed on 12/13/14 that was incomplete. The assessment failed to evidence the nurse had assessed the patient's temperature and respirations at the start of care visit.</p> <p>On 2/3/15 at 2:15 PM, the administrator indicated the initial / start of care assessment was not complete.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include: initial and ongoing assessments of the patient's needs, including OASIS assessments at appropriate points in time</p>			

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G 172 Bldg. 00	<p>... initiating the plan of care and revising as necessary."</p> <p>4. The agency policy titled "Initial and comprehensive assessment" with a revised date of May 2010 stated, "An initial assessment will be performed and documented in the patient's clinical record by a registered nurse ... the initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician, or at the patient / family request with the approval of the physician ... a comprehensive patient assessment will be completed within 5 calendar days of the patient' start of care ... the assessment will be patient specific and comprehensive to include the patient's need for home care ... a physical assessment, including blood pressure, temperature, respiration, skin, pain status ... and other relevant data related to pertinent physical status ... equipment presently in the home and potentially needed by the patient."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates</p>			

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	<p>the patients nursing needs.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the registered nurse reevaluated the patient's needs at time of recertification for 2 of 6 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days (#11 and #12).</p> <p>Findings</p> <p>1. Clinical record #11, start of care 8/9/14 and a primary diagnosis of unspecified hypertensive heart disease with heart failure, included a plan of care for the certification period of 12/27/14 - 2/4/15. The patient was still on service and did not have a recertification assessment completed during the last 5 days of the prior certification period.</p> <p>On 2/10/15 at 12:35 PM, the administrator indicated the patient was still on service and had not had a recertification assessment completed by the registered nurse.</p> <p>2. Clinical record #12, start of care date 5/8/14 and diagnosis of open wound of the breast, included plans of care for the certification periods of 11/4/14 - 1/2/15 and 1/3/15 - 3/3/15. The registered nurse</p>	G 172	<p>The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the standard,484.30(a), Duties of the Registered Nurse, that the registered nurse regularly re-evaluates the patients nursing needs, and also reviewing the company policies on Scope and Services, Reassessment/ Recertification, and Admission Criteria and Process. The Administrator and Director of Nursing have further discussed with those employees individually that were directly associated with clinical record findings during the survey reviewing the standard and agency policies to ensure this deficiency may not recur with those employees as the registered nurse regularly re-evaluates the patients nursing needs. On Clinical Record#12 SOC 5/8/14, the registered nurse, Employee J, who visited with the patient has coordinated the recertification assessment with the Administrator as Employee J was called during the survey for a phone interview. The surveyor Ingrid Miller, PHNS, RN then called Joyce Elder, MSN, BSN, RN to confirm if this coordination was OK, and has stated that coordination of the recertification assessment was acceptable. Copy of Employee J's recertification assessment is attached and signed (See Attachment 5). The Director of</p>	03/06/2015

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	<p>who visited the patient on 1/2/15 did not complete the oasis recertification assessment on 1/2/15. The record failed to evidence the registered nurse had completed the recertification assessment during the 5 day window. The administrator completed the oasis assessment without visiting the patient. The clinical record evidenced a skilled nursing visit by Employee J on 1/2/15 and an oasis document completed by the administrator on the same day. The pain assessment had not been completed for this visit on the assessment.</p> <p>A. On 1/9/15 at 3:45 PM, Employee M, Registered Nurse, indicated visiting the patient on 1/2/15. An oasis assessment was not completed.</p> <p>B. On 1/9/15 at 3:45 PM, the administrator indicated completing the oasis transmission by discussing the visit with the RN, Employee M The administrator indicated the pain assessment was not complete for this assessment.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and</p>		<p>Nursing and Quality Assurance Nurse are also to in-service the skilled nursing staff on March 06, 2015 of the standard and company policies that the registered nurse is to regularly re-evaluates the patients nursing needs. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions and to ensure this deficiency is corrected and will not recur, and to report all findings to the Director of Nursing whom is responsible that the deficiency has been corrected and compliance maintained.</p>	

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	<p>include: initial and ongoing assessments of the patient's needs, including OASIS assessments at appropriate points in time ... initiating the plan of care and revising as necessary ... physician services are provided by the licensed Doctor of Medicine, Osteopathy, and Podiatrist and include ... developing and / or authorizing the plan of care ... submitting signed orders for plans of care and changes in accordance with required time frames."</p> <p>4. The agency policy titled "Reassessment / Recertification" with a revised date of May 2010 stated, "The comprehensive assessment must be updated and revised every 60 days beginning with the start of care ... documentation in the clinical record should support the assessment as well as the actions taken in response."</p> <p>5. The agency policy titled "Admission Criteria and Process" with a revised date of May 2010 stated, "The patient must be under the care of a physician. The patient's physician ... must order and approve the provision of any service ... The initial assessment must be performed within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician."</p>			

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G 225  Bldg. 00	<p>484.36(c)(2) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on home visit observation, personnel file review, clinical record review, policy review, and interview, the agency failed to ensure the home health aide (Employee D) only performed tasks which the aide was allowed to do by law and in the aide's scope of practice for 1 of 7 active records reviewed of patients with home health aide services (#1) and 2 of 2 home visit observations of patients (4 and 8) receiving home health aide services (C and E).</p> <p>Findings</p> <p>Regarding a task completed outside the aide's scope of practice</p> <p>1. On 2/4/15 at 10:45 AM, patient #1 was observed to have a Band-Aid on the right lower leg. The leg had redness and bruising around this area. No open area was noted. This visit was to observe a physical therapist caring for the patient.</p> <p>A. On 2/4/15 at 10:45 AM, patient #1 indicated the home health aide</p>	G 225	<p>The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the standard 484.36(c)(2) Assignment and Duties of Home Health Aide, that the home health aide provides services that are ordered by the physician in the plan of care and the aide is permitted to perform under state law. Further reviewing agency policies on Scope of Services and Home Health Aide Job Description. The Administrator and Director of Nursing have discussed the findings with Employee D, home health aide, and have reviewed the standard and agency policies, especially the Home Health Aide Job Description. Employee D, home health aide, has verbalized understanding of the deficiency and the importance of following the Home Health Aide Care Plan. The Administrator and Director of Nursing and Quality Assurance Nurse have in-serviced all Home Health Aides on February 23, 2015 on the importance of following the Home Health Aide Care Plan developed by the registered nurse. The Care plan is developed to provide adequate care to the client. The Quality</p>	02/11/2015

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	<p>(HHA), Employee D, dressed the wound on the right lower leg after every shower. The patient indicated an informal caregiver had applied the Band-Aid after the dressing had fallen off. The patient indicated the HHA would arrive at the home later that morning to give the patient a shower and reapply the ointment and dressing.</p> <p>B. On 2/4/15 at 1 PM, Employee D indicated the Registered Nurse, Employee F, had told her to complete this task after every shower completed for patient #1. She had not documented this task on her home health aide visit notes. This was a phone interview.</p> <p>C. On 2/4/15 at 1:10 PM, Employee A, the administrator, indicated Employee D should not have complete this task as it was not in her scope of practice and the task had not been on the visit notes completed by the HHA.</p> <p>D. On 2/5/15 at 2:15 PM, Employee F indicated not being able to recall instructing Employee D to apply the ointment and dress the wound on the right leg. This was a phone interview.</p> <p>E. Clinical record #1 evidenced the patient received a new order for cleaning a wound on the right lower leg and then</p>		Assurance Nurse will audit 10% of clinical records observing Home Health Aide Care Plans/ HHA visit notes to ensure compliance with patient care, and that the care plan is being followed quarterly through 02-2016 and to monitor these corrective actions and to ensure that this deficiency is corrected and will not recur, and report all findings to the Director of Nursing and Administrator whom are responsible that the deficiency has been corrected and compliance maintained.	

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	<p>applying triple antibiotic ointment daily and covering with gauze and as needed to traumatic wound on 1/22/15. A skilled nurse visit on 1/22/15 from 2 - 3 PM evidenced Employee F had documented a new wound and called the physician for a new order. He had also cleansed and dressed the wound on this date. There was no communication note for the aide to complete this task in the record.</p> <p>F. The personnel file of Employee D, HHA, evidenced a skills checklist completed for this HHA on 10/14/08. This competency skills checklist failed to evidence the HHA was competent in cleansing wounds, applying medicated ointments, or applying dressings.</p> <p>2. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Home health duties include A. assisting with personal hygiene B. assisting with ambulation and exercise C. Assisting with medications that are ordinarily self - administered [per state regulations] d. reporting changes in the patient's condition E. Providing nutritional support F. Other supportive tasks as assigned."</p> <p>3. The agency policy titled "Home Health VI" with a revised date of May 2010 stated, "Job limitations ... the home</p>			

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G 242 Bldg. 00	<p>health aide will not function in any manner viewed as the practice of nursing according the state's Nurse Practice Act. Specifically, the home health aide will not administer medications, take physician's orders or perform procedures requiring the training, knowledge and skill of a nurse, such as sterile techniques."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM</p> <p>Based on administrative record and agency policy review and interview, it was determined the agency failed to have an annual evaluation of the agency's total program that included policy and administrative review (see G 244); failed to ensure an annual review was completed that assessed the extent to which the agency's program is appropriate, adequate, effective, and efficient (see G 245); failed to have an annual evaluation of the agency's total program (see G 246); failed to have an annual evaluation of the agency's total program that was maintained as a separate administrative record (see G 247); failed to ensure an annual evaluation was completed that included a review of policies and administrative practices to determine the extent to which</p>	G 242	The Administrator and the Director of Nursing and Quality Assurance Nurse have reviewed the condition 484.52, Evaluation of the Agency's Program and agency policy on Annual Organization Evaluation. Further reviewing the condition in detail determining the immediate needs of the agency for an annual evaluation of the agency's total program that includes the following: policy and administrative review; assessing the extent to which the agency's program is appropriate,adequate, effective, and efficient; evaluation of the agency's total program;and that the evaluation was maintained as a separate administrative record; and that the annual evaluation includes a review of policies and administrative practices to	03/11/2015

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	<p>they promote patient care that is appropriate, adequate, effective, and efficient (see G 248); and failed to ensure mechanisms were in place for the collection of data for the annual evaluation (see G 249).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 42 CFR 484.52 Evaluation of the Agency's Program.</p>		<p>determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient; and that mechanisms were in place for the collection of data for the annual evaluation. An immediate evaluation of the agency's organization is to be conducted to obtain an overall baseline of the agency's current program. The Administrator is to review the current oversight committee members and to appoint new members as needed for the organization. The committee is then to meet on 02/27/2015 and evaluate the agency's total program, the program complexity, the extent to which the agency's program is appropriate, adequate, effective, and efficient; and to ensure the mechanisms that are in place for the collection of data for the next annual evaluation. The Administrator is responsible for any evaluation records of the agency's total program and is also to maintain those records in the agency's administrative record. The Administrator is also responsible for the ongoing maintenance ensuring mechanisms are in place for the collection of data for the annual evaluations, and overall supervision of the agency's total program thereof. The Director of Nursing and Quality Assurance Nurses are to assist the Administrator on this condition.</p>	

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G 244  Bldg. 00	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review.</p> <p>Based on administrative record and agency policy review and interview, it was determined the agency failed to have an annual evaluation of the agency's total program that included policy and administrative review for 1 of 1 agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to evidence an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency.</li> <li>2. On 2/10/15 at 2:05 PM, the director of nursing indicated a total evaluation of the agency had not been completed for the agency.</li> <li>3. On 2/10/15 at 2:10 PM, the administrator indicated not being able to find the governing body minutes since 2012.</li> <li>4. The agency policy titled "Annual</li> </ol>	G 244	The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the condition 484.52, Evaluation of the Agency's Program and agency policy on Annual Organization Evaluation, further reviewing the condition determining the needs of the agency for an annual evaluation of the agency's total program that consists of policy review and administrative review. An immediate evaluation of the agency's organization is to be conducted to obtain an overall baseline of the agency's current program. The committee is to meet on 02/27/2015 and evaluate the agency's total program, the program's complexity, and to ensure that evaluation of the agency's total program includes policy and administrative reviews. The Administrator is to ensure that the evaluation of the agency's total program includes policy and administrative reviews. The Administrator is to also present the findings to the agency's oversight committee annually to prevent any further deficiencies from recurring of this condition. The Director of Nursing and Quality Assurance Nurse are to assist the Administrator on this	03/11/2015	

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G 245 Bldg. 00	<p>Organization Evaluation" with a revised date of May 2010 stated, "the organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.</p> <p>Based administrative record and policy review and interview, the agency failed to ensure an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness,</p>	G 245	<p>condition.</p> <p>The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the condition 484.52, Evaluation of the Agency's Program and agency policy on Annual Organization Evaluation, further reviewing the condition</p>	03/11/2015

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	<p>and efficiency had been completed since the agency's certification in 2012 creating the potential to affect all of the agency's 75 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to evidence an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency.</li> <li>2. On 2/10/15 at 2:05 PM, the director of nursing indicated a total evaluation of the agency had not been completed for the agency.</li> <li>3. On 2/10/15 at 2:10 PM, the administrator indicated not being able to find the governing body minutes since 2012.</li> <li>4. The agency policy titled "Annual Organization Evaluation" with a revised date of May 2010 stated, "the organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the</li> </ol>		<p>determining the needs of the agency for an annual evaluation of the agency's total program that includes assessment of the extent to which the agency's program is appropriate, adequate, effective, and efficient. An immediate evaluation of the agency's organization is to be conducted to obtain an overall baseline of the agency's current program. The committee is to meet on 02/27/2015 and evaluate the agency's total program, the program's complexity, and to assess the extent to which the agency's program is appropriate, adequate, effective, and efficient. The Administrator is to ensure that the evaluation of the agency's total program has assessed the extent to which the agency's program is appropriate, adequate, effective, and efficient. The Administrator is to also present the findings to the agency's oversight committee annually to prevent any further deficiencies from recurring of this condition. The Director of Nursing and Quality Assurance Nurse are to assist the Administrator on this condition.</p>	

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G 246 Bldg. 00	<p>effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency.</p> <p>Based on administrative record and agency policy review and interview, it was determined the agency failed to have an annual evaluation of the agency's total program for 1 of 1 agency.</p> <p>Findings</p> <p>1. The agency's administrative records failed to evidence an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency.</p>	G 246	The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the condition 484.52, Evaluation of the Agency's Program and agency policy on Annual Organization Evaluation. Further reviewing the condition determining the needs of the agency for an annual evaluation of the agency's total program that includes results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. An immediate evaluation of the agency's organization is to be conducted to obtain an overall baseline of the agency's current	03/11/2015

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G 247	<p>2. On 2/10/15 at 2:05 PM, the director of nursing indicated a total evaluation of the agency had not been completed for the agency.</p> <p>3. On 2/10/15 at 2:10 PM, the administrator indicated not being able to find the governing body minutes since 2012.</p> <p>4. The agency policy titled "Annual Organization Evaluation" with a revised date of May 2010 stated, "the organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.52 EVALUATION OF THE AGENCY'S</p>		<p>program. The committee is to meet on 02/27/2015 and evaluate the agency's total program, the program's complexity, and results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. The Administrator is responsible for the results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. The Administrator is to also present the findings to the agency's oversight committee annually to prevent any further deficiencies from recurring of this condition. The Director of Nursing and Quality Assurance Nurse are to assist the Administrator on this condition.</p>		

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Bldg. 00	<p><b>PROGRAM</b></p> <p>Results of the evaluation are maintained separately as administrative records. Based on administrative record and agency policy review and interview, it was determined the agency failed to have an annual evaluation of the agency's total program that was maintained as a separate administrative record for 1 of 1 agency.</p> <p>Findings</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to evidence an evaluation of the agency's total program that was maintained as a separate administrative record.</li> <li>2. On 2/10/15 at 2:05 PM, the director of nursing indicated a total evaluation of the agency had not been completed for the agency.</li> <li>3. On 2/10/15 at 2:10 PM, the administrator indicated not being able to find the governing body minutes since 2012.</li> <li>4. The agency policy titled "Annual Organization Evaluation" with a revised date of May 2010 stated, "the organization will appoint an authorized group or oversight committee to conduct</li> </ol>	G 247	<p>The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the condition 484.52, Evaluation of the Agency's Program and agency policy on Annual Organization Evaluation, further reviewing the condition determining the needs of the agency for an annual evaluation of the agency's total program that includes that the evaluation is maintained as a separate administrative record. An immediate evaluation of the agency's organization is to be conducted to obtain an overall baseline of the agency's current program. The committee is to meet on 02/27/2015 and evaluate the agency's total program, the program's complexity, and to ensure the results of the evaluation are maintained separately as administrative records. The Administrator is responsible for any evaluation records of the agency's total program and is also to maintain those records in the agency's administrative record. The Administrator is to also present the findings to the agency's oversight committee annually to prevent any further deficiencies from recurring of this condition. The Director of Nursing and Quality Assurance Nurse are to assist the Administrator on this</p>	03/11/2015

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G 248 Bldg. 00	<p>an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient.</p> <p>Based on administrative record and agency policy review and interview, it was determined the agency failed to ensure an annual evaluation was completed that included a review of policies and administrative practices to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient for 1 of</p>	G 248	<p>condition.</p> <p>The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the condition 484.52, Evaluation of the Agency's Program and agency policy on Annual Organization Evaluation, further reviewing the condition in detail determining the needs of the agency for an annual evaluation of the agency's total program that includes are view of policies and administrative practices. An</p>	03/11/2015

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	<p>1 agency.</p> <p>Findings</p> <p>1. The agency's administrative records failed to evidence an evaluation of the agency's total program that assessed the agency's appropriateness, adequacy, effectiveness, and efficiency.</p> <p>2. On 2/10/15 at 2:05 PM, the director of nursing indicated a total evaluation of the agency had not been completed for the agency.</p> <p>3. On 2/10/15 at 2:10 PM, the administrator indicated not being able to find the governing body minutes since 2012.</p> <p>4. The agency policy titled "Annual Organization Evaluation" with a revised date of May 2010 stated, "the organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial</p>		<p>immediate evaluation of the agency's organization is to be conducted to obtain an overall baseline of the agency's current program. The committee is to meet on 02/27/2015 and evaluate the agency's total program, the program's complexity, and to ensure there is a review of the agency policies and administrative practices of the agency. The Administrator is responsible for the evaluation of the agency's program and to ensure that there is inclusion of the review of policies and administrative practices of the agency. The Administrator is to also present the findings to the agency's oversight committee annually to prevent any further deficiencies from recurring of this condition. The Director of Nursing and Quality Assurance Nurse are to assist the Administrator on this condition.</p>		

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G 249 Bldg. 00	<p>performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.</p> <p>Based on administrative record and agency policy review and interview, it was determined the agency failed to ensure mechanisms were in place for the collection of data for the annual evaluation for 1 of 1 agency.</p> <p>Findings</p> <p>1. The agency's administrative records failed to evidence mechanisms were in place for the collection of data for the annual evaluation.</p> <p>2. On 2/10/15 at 2:05 PM, the director of nursing indicated a total evaluation of the agency had not been completed for the agency.</p>	G 249	The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the condition 484.52, Evaluation of the Agency's Program and agency policy on Annual Organization Evaluation, further reviewing the condition in detail determining the needs of the agency for an annual evaluation of the agency's total program that includes that mechanisms are in place and established in writing for the collection of data for the annual evaluation. An immediate evaluation of the agency's organization is to be conducted to obtain an overall baseline of the agency's current program. The committee is to meet on 02/27/2015 and evaluate the agency's total program, the program's complexity, and to ensure the mechanisms are in place and established for the collection of data for the annual evaluation. The Administrator is	03/11/2015

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G 330 Bldg. 00	<p>3. On 2/10/15 at 2:10 PM, the administrator indicated not being able to find the governing body minutes since 2012.</p> <p>4. The agency policy titled "Annual Organization Evaluation" with a revised date of May 2010 stated, "the organization will appoint an authorized group or oversight committee to conduct an annual evaluation to assess the organization's program. The complexity of the organization and the scope of services and products will define the parameters for data collection. The evaluation will include an analysis of the effectiveness of the organizational administrative practices, risk management, human resources, financial performance, and policies and procedures based on defined measures of program appropriateness and efficiency ... the annual evaluation report is submitted to the appropriate oversight committee and the governing body for review."</p> <p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used</p>		<p>responsible for ensuring mechanisms are in place and established for the collection of data for the annual evaluations. The Administrator is to also present the findings to the agency's oversight committee annually to prevent any further deficiencies from recurring of this condition. The Director of Nursing and Quality Assurance Nurse are to assist the Administrator on this condition.</p>	

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	<p>to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on observation, policy and clinical record review, and interview, it was determined the agency failed to ensure the registered nurse had made an initial assessment visit within 48 hours of referral in 1 of 12 records (see G 332), failed to ensure the start of care / comprehensive assessment was complete for 2 of 12 records reviewed (see G 334), and failed to ensure the registered nurse completed a recertification comprehensive assessment for 2 of 6 active records reviewed for patients receiving services over 60 days (see G 338).</p> <p>The cumulative effect of these systemic</p>	G 330	The Administrator, Director of Nursing, and Quality Assurance Nurse have review the condition, 484.55, of: ensuring the registered nurse had made an initial assessment visit within 48 hours of referral, the start of care/ comprehensive assessment was completion, and ensuring the registered nurse completed a recertification comprehensive assessment. The Administrator, Director of Nursing, and Quality Assurance Nurse have further reviewed those clinical records with findings and have discussed with the clinicians doing the comprehensive assessment to review the condition and company policies of the Comprehensive Assessment of Patients regarding the initial assessment visit within 48 hours, the completion of the start of care/ comprehensive	03/06/2015

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G 332 Bldg. 00	<p>problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.55 Comprehensive Assessment of Patients.</p> <p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on clinical record review and interview, the agency failed to ensure the registered nurse made an initial assessment visit within 48 hours of referral in 1 of 12 records (#11) reviewed creating the potential to affect all of the agency's new patients.</p> <p>The findings include</p> <p>1. Clinical record #11, start of care 8/9/14, failed to evidence a referral date or document in the record so it was</p>	G 332	<p>assessment, and recertification comprehensive assessment. The Administrator, Director of Nursing, and Quality Assurance Nurse will have an in-service on 03/06/2015 to the agency's staff and skilled nursing staff about the condition going over the company policies. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions and to ensure this deficiency is corrected and will not recur, and to report all findings to the Director of Nursing whom is responsible that the deficiency has been corrected and compliance maintained.</p> <p>The Administrator, Director of Nursing, and Quality Assurance Nurse have reviewed the condition, 484.55(a)(1), Initial Assessment Visit, and company policies on Intake Process, Admission Criteria and Process, and Initial Comprehensive Assessment. The Administrator, Director of Nursing, and Quality Assurance Nurse will have an in-service on 03/06/2015 to the agency's staff about the condition going over the company policies regarding the Initial Assessment Visit. Home health care referrals</p>	03/06/2015

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	<p>unable to be determined if any initial assessment visit was made within 48 hours.</p> <p>On 2/10/15 at 11:20 AM, the administrator indicated she thought the referral document was the face to face physician encounter and there was no referral in the record.</p> <p>2. The agency policy titled "Intake Process" with a revised date of May 2010 stated, "To establish the process for acceptance and entry of patient into organization ... Home health care referrals will be documented on a referral and intake form ... the clinical supervisor will assign personnel and schedule an initial assessment visit. The initial assessment visit will be performed either within 48 hours of the referral, or within 48 hours of the patient's return home, or on the start of care date ordered by the physician."</p> <p>3. The agency policy titled "Admission Criteria and Process" with a revised date of May 2010 stated, "The patient must be under the care of a physician. The patient's physician ... must order and approve the provision of any service ... The initial assessment must be performed within 48 hours of the referral, within 48 hours of the patient's return home, or on</p>		<p>will be documented on a referral and intake form. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions and to ensure this deficiency is corrected and will not recur, and to report all findings to the Director of Nursing whom is responsible that the deficiency has been corrected and compliance maintained.</p>	

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G 334  Bldg. 00	<p>the start of care date ordered by the physician."</p> <p>4. The agency policy titled "Initial and comprehensive assessment" with a revised date of May 2010 stated, "An initial assessment will be performed and documented in the patient's clinical record by a registered nurse ... the initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician, or at the patient / family request with the approval of the physician ... a comprehensive patient assessment will be completed within 5 calendar days of the patient' start of care ... the assessment will be patient specific and comprehensive to include the patient's need for home care ... a physical assessment, including blood pressure, temperature, respiration, skin, pain status ... and other relevant data related to pertinent physical status ... equipment presently in the home and potentially needed by the patient."</p> <p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent</p>			

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	<p>with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on home visit observation, policy and clinical record review, and interview, the agency failed to ensure the start of care comprehensive assessment was complete for 2 of 12 records reviewed (#1 and #9).</p> <p>Findings</p> <p>1. Clinical record # 1, start of care 12/16/14 and diagnosis of unspecified hypertensive heart disease without heart failure, evidenced a comprehensive assessment was completed on 12/16/14 that lacked a physical assessment of the location of the pacemaker on the patient and lacked documentation concerning a medical monitoring device for the electronic monitoring of the pacemaker was present in the home at the bedside of the patient.</p> <p>a. On 2/4/15 at 10 AM, patient #1 indicated having a pacemaker on the left side of the chest and a medical monitoring device to electronically evaluate the pacemaker in the home. Patient #1 indicated having the pacemaker and electronic monitoring device since March of 2014.</p>	G 334	<p>The Administrator, Director of Nursing, and Quality Assurance Nurse have review the condition, 484.55(b)(1), Completion of the Comprehensive Assessment, and company policies on Scope of Services and Initial and Comprehensive Assessment. The Administrator and Director of Nursing have discussed with Clinical Record #1's skilled nurse reviewing the condition and company policies in relation to the findings, although the findings were not consistent with the patient's immediate needs an order was obtained to include the assessment in the patient's plan of care (See Attachment 4). The Administrator and Director of Nursing have discussed with Clinical Record #9's skilled nurse reviewing the condition and company policies in relation to the findings for the importance of and completion of the comprehensive assessment thoroughly and employee has verbalized understanding. The Administrator, Director of Nursing, and Quality Assurance Nurse will have an in-service on 03/06/2015 to the agency's staff about the condition going over the company policies regarding the Completion of the Comprehensive Assessment. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for</p>	03/06/2015

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	<p>b. On 2/4/15 at 10:05 AM, a cardiac monitoring device for the patient's pacemaker electronic device was noted by the bedside of patient #1.</p> <p>c. On 12/4/14 at 4:10 PM, the administrator indicated the comprehensive assessment failed to show the patient had a pacemaker or a electronic monitoring device for the pacemaker present in the home.</p> <p>2. Clinical record # 9, start of care 12/13/14 and diagnosis of post traumatic seizures, evidenced an initial start of care / comprehensive assessment was completed on 12/13/14 that was incomplete. The assessment failed to evidence the nurse had assessed the patient's temperature and respirations at the start of care visit.</p> <p>On 2/3/15 at 2:15 PM, the administrator indicated the initial / start of care assessment was not complete.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include: initial and ongoing assessments</p>		<p>compliance and to monitor these corrective actions and to ensure this deficiency is corrected and will not recur, and to report all findings to the Director of Nursing whom is responsible that the deficiency has been corrected and compliance maintained.</p>	

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	<p>of the patient's needs, including OASIS assessments at appropriate points in time ... initiating the plan of care and revising as necessary."</p> <p>4. The agency policy titled "Initial and comprehensive assessment" with a revised date of May 2010 stated, "An initial assessment will be performed and documented in the patient's clinical record by a registered nurse ... the initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician, or at the patient / family request with the approval of the physician ... a comprehensive patient assessment will be completed within 5 calendar days of the patient' start of care ... the assessment will be patient specific and comprehensive to include the patient's need for home care ... a physical assessment, including blood pressure, temperature, respiration, skin, pain status ... and other relevant data related to pertinent physical status ... equipment presently in the home and potentially needed by the patient."</p>			

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G 338 Bldg. 00	<p>484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the registered nurse completed a recertification comprehensive assessment for 2 of 6 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days (#11 and #12).</p> <p>Findings</p> <p>1. Clinical record #11, start of care 8/9/14 and a primary diagnosis of unspecified hypertensive heart disease with heart failure, included a plan of care</p>	G 338	The Administrator, Director of Nursing, and Quality Assurance Nurse have review the condition, 484.55(d), Update of the Comprehensive Assessment, and company policies on Scope of Services, Reassessment/ Recertification, and Admission Criteria and Process. The Administrator and Director of Nursing have discussed with Clinical Record 11's skilled nurse reviewing the condition and company policies in relation to the findings for the importance of and completion of the comprehensive assessment to be updated and revised with the completion of the recertification comprehensive assessment. The Adminstrator, Director of Nursing, and Quality Assurance Nurse will have	03/06/2015

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	<p>for the certification period of 12/27/14 - 2/4/15. The patient was still on service and did not have a recertification assessment completed during the last 5 days of the prior certification period.</p> <p>On 2/10/15 at 12:35 PM, the administrator indicated the patient was still on service and had not had a recertification assessment completed by the registered nurse.</p> <p>2. Clinical record #12, start of care date 5/8/14 and diagnosis of open wound of the breast, included plans of care for the certification periods of 11/4/14 - 1/2/15 and 1/3/15 - 3/3/15. The registered nurse who visited the patient on 1/2/15 did not complete the oasis recertification assessment on 1/2/15. The record failed to evidence the registered nurse had completed the recertification assessment during the 5 day window. The administrator completed the oasis assessment without visiting the patient. The clinical record evidenced a skilled nursing visit by Employee J on 1/2/15 and an oasis document completed by the administrator on the same day. The pain assessment had not been completed for this visit on the assessment.</p> <p>A. On 1/9/15 at 3:45 PM, Employee M, Registered Nurse, indicated visiting</p>		<p>in-service on 03/06/2015 to the agency's staff about the condition going over the company policies regarding the importance of updating and revision of the comprehensive assessment. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions and to ensure this deficiency is corrected and will not recur, and to report all findings to the Director of Nursing whom is responsible that the deficiency has been corrected and compliance maintained.</p>	

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	<p>the patient on 1/2/15. An oasis assessment was not completed.</p> <p>B. On 1/9/15 at 3:45 PM, the administrator indicated completing the oasis transmission by discussing the visit with the RN, Employee M The administrator indicated the pain assessment was not complete for this assessment.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include: initial and ongoing assessments of the patient's needs, including OASIS assessments at appropriate points in time ... initiating the plan of care and revising as necessary ... physician services are provided by the licensed Doctor of Medicine, Osteopathy, and Podiatrist and include ... developing and / or authorizing the plan of care ... submitting signed orders for plans of care and changes in accordance with required time frames."</p> <p>4. The agency policy titled "Reassessment / Recertification" with a revised date of May 2010 stated, "The comprehensive assessment must be updated and revised every 60 days</p>			

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N 000 Bldg. 00	<p>beginning with the start of care ... documentation in the clinical record should support the assessment as well as the actions taken in response."</p> <p>5. The agency policy titled "Admission Criteria and Process" with a revised date of May 2010 stated, "The patient must be under the care of a physician. The patient's physician ... must order and approve the provision of any service ... The initial assessment must be performed within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician."</p> <p>This visit was for a state home health relicensure survey.</p> <p>Survey date: February 3 - 10, 2015</p> <p>Facility #: 011121</p> <p>Medicaid vendor #: 200839240</p> <p>Surveyor: Ingrid Miller, PHNS, RN Tameka Warren, PHNS, RN</p> <p>Skilled unduplicated census: 155</p>	N 000		

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N 456 Bldg. 00	<p>Quality Review: Joyce Elder, MSN, BSN, RN February 16, 2015</p> <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> <p>Based administrative record review and interview, the administrator failed to ensure the agency had an ongoing Quality Assurance program to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care creating the potential to affect all of the agency's 75 current patients.</p> <p>The findings include:</p> <p>1. The agency's administrative records failed to evidence an ongoing Quality Assurance program to objectively and</p>	N 456	<p>The Quality Assurance program was reviewed by the Administrator, the Director of Nursing and the Quality Assurance Nurse in accordance to the Rule, 410 IAC 17-12-1(e), Home Health agency administration/management. Revisions have been made to identify problems, to resolve and improve patient care, and to monitor and evaluate the quality and appropriateness, objectively and systematically. The agency's administrative records will reflect the ongoing Quality Assurance program and the reports of the evaluations will be presented to the Professional Advisory Committee to confer as accorded by the Administrator on a quarterly basis or more frequently, to ensure the quality</p>	03/11/2015

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	<p>systematically monitor and evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care.</p> <p>2. On 2/10/15 at 2:05 PM, the director of nursing indicated the agency did not have a quality assurance program.</p>		<p>assurance program is ongoing, as the administrator is responsible for this. During the survey, the Director of Nursing did discuss the identified problems within the agency with Surveyors Ingrid Miller, PHNS, RN and Tameka Warren PHNS, RN. The Director of Nursing identified a particular problem currently in the agency with wound care, and how to plan care appropriately for home health services for patient needs. Actual data was shown of wound measurements obtained and collected from clinical records in an Excel format over time. Further explanation by the Director of Nursing shows how wound measurements trend over time and approximate date discharge or ongoing services can be determined for appropriate planning and coordination in an effective manner as analysis of this data is evaluated also estimating possible discharge from home health. The Director of Nursing is to further implement and maintain this assessment among all patient's that may have a wound to improve care for those patients with wounds. This will further be coordinated with the Administrator for the Agency's records. The Administrator is responsible for monitoring compliance to the quality assurance program. Clinical record reviews will continue on a</p>	

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N 470 Bldg. 00	<p>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 review of policy and procedures, the agency failed to ensure staff had provided services in accordance to their own infection control polices in 2 of 6 home visit observations with patients #3 and #8 creating the potential to affect any patients cared for by employee E, home health aide, and employee H, Registered Nurse.</p> <p>Findings:</p> <p>1. Home visit observation made on 2/5/15 at 9:10 AM to patient #3 with employee H, Registered Nurse (RN).</p> <p>A. At 9:15 AM, the RN was observed taking the patient's blood pressure after which she returned the blood pressure cuff to her nursing bag without disinfecting it.</p> <p>B. At 9:30 AM, the RN was observed</p>	N 470	<p>quarterly basis. Educational in-services for the field staff pertaining to the identified deficiencies will be instituted immediately.</p> <p>The Administrator and Director of Nursing reviewed the rule, 410 IAC 7-12-1(m), Home Health agency administration/ management that policies and procedures shall be written and implemented for the control of communicable diseases in compliance with applicable federal and state laws; also, further reviewing the agency's policies on Hand Hygiene, Standard Precautions, and Bag Technique. The Administrator, Director of Nursing, and Quality Assurance Nurse then reviewed individually with employees H and E specifically regarding the observations during home visits. Employees E and H have both verbalized understanding of the deficiency after going over the rule, agency policies, and the procedures. The Director of Nursing held an in-service on February 23, 2015 to discuss with field staff about the rule, policies and procedures implemented for</p>	02/23/2015

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	<p>changing the patient's dressing to coccyx.</p> <p>The patient had stool present at the time of wound dressing change. RN cleaned stool off patient with baby wipes, laid soiled baby wipes on chuck under patient. When completed cleaning patient, rolled chuck under patient and dipped soiled gloved hand into Silvadene topical cream and applied to patient's coccyx, left open to air. Placed new chuck under patient and turned patient back over.</p> <p>Repositioned patient with help of family friend and removed gloves and applied new gloves without disinfecting hands.</p> <p>C. At 9:45 AM, the RN was observed changing the patient's dressing to G-tube stoma. The RN removed old dressing and with the same gloves used to remove the old dressing, the RN cleansed the site with normal saline and applied clean split gauze. The RN stated she was having difficulty using the paper tape with gloved hands. The roll of paper tape that had been handled with soiled gloves was returned to her zip lock bag of supplies, she then removed another roll of tape from the zip lock bag. The RN then removed her gloves and without disinfecting her hands continued to</p>		<p>the control of communicable disease in the agency, specifically infection control, wound care management and hand hygiene education, glove technique demonstration and bag technique demonstration. The Administrator, the Director of Nursing along with the Quality Assurance Nurse will be responsible for monitoring compliance with policies and procedures implemented for control of communicable disease. To enforce compliance, yearly competency evaluation with return demonstration, will be required, of all field staff.</p>	

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	<p>complete and finish applying the dressing to the patients G-tube site without gloves. She then placed the paper tape used to complete the dressing change back into the zip lock bag of supplies. She cleaned up her work area including the old dressing and used supplies without gloves on. She then returned her zip locked bag of supplies to her nursing bag without disinfecting them and without washing or disinfecting hands before placing supplies in nursing bag.</p> <p>D. Interview on 2/6/15 at 2:15 PM, the agency's administrator and Director of Nursing (DON) agreed the employee H, RN, should have disinfected hands between glove changes, gloves should have been worn for the duration of wound care, and supplies should have been disinfected before reinserting them in the nursing bag for care provided to Patient #3 during home visit.</p> <p>2. Home visit observation made on 2/6/15 at 10:20 AM to patient #8 with employee E, Home Health Aide (HHA).</p> <p>A. At 11:10 AM, after the patient's bath employee E, placed zip locked bags of supplies into nursing bag with gloves on that were used to bath the patient.</p>			

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	<p>B. Interview on 2/6/15 at 1:45 PM, the agency's administrator and DON agreed that the employee E, HHA, should have removed gloves and washed hands before placing supplies into nursing bag.</p> <p>3. The agencies policy titled "Hand Hygiene", dated May 2010, states, "Purpose: To prevent cross-contamination and home care-acquired infections ... 3. Hand decontamination using an alcohol-based hand rub should be performed ... G. After removing gloves ... ."</p> <p>4. The agencies policy titled "Standard Precautions ", dated May 2010, states, "Purpose: To reduce the risk of exposure to and transmission of infections when caring for patients ... 1. Gloves ... Gloves are to be worn when ... 1. There is actual or potential contact with blood or other potentially infectious materials ... 11. Performing wound care ... C. Gloves are to be changed: 1. Between tasks and procedures on the same patient 2. During changing or cleaning an incontinent patient 3. After removing an old dressing ... ."</p> <p>5. The agencies policy titled "Bag Technique", dated May 2010, states,</p>			

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N 472 Bldg. 00	<p>"Purpose: To describe the procedure for maintaining a clean nursing bag and preventing cross contamination ... 5. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to bag... ."</p> <p>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 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 administrative record review and interview, the administrator failed to ensure the agency developed, implemented, maintained, and evaluated</p>	N 472	The Administrator, the Director of Nursing, and Quality Assurance Nurse reviewed the quality assurance and performance improvement program to identify the immediate needs of the agency that will result in	03/11/2015

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	<p>a quality assessment and performance improvement program that reflected the complexity of the home health organization and services creating the potential to affect all of the agency's 75 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's administrative records failed to evidence the agency developed, implemented, maintained, and evaluated a quality assessment and performance improvement program that reflected the complexity of the home health organization and services</li> <li>2. On 2/10/15 at 2:05 PM, the director of nursing indicated the agency did not have a quality assurance program.</li> </ol>		<p>improvements of the agency's performance and patient care. It was reviewed within the agency that immediate needs identified were progression of wound healing patients and obtaining signed physician orders within stated time frames. During the survey, the Director of Nursing did discuss the identified problems within the agency with Surveyors Ingrid Miller, PHNS, RN and Tameka Warren PHNS, RN. The Director of Nursing identified a particular problem currently in the agency with wound care, and how to plan care appropriately for home health services for patient needs. Actual data was shown of wound measurements obtained and collected from clinical records in an Excel format over time. Further explanation by the Director of Nursing shows how wound measurements trend over time and approximate date discharge or ongoing services can be determined for appropriate planning and coordination in an effective manner as analysis of this data is evaluated also estimating possible discharge from home health. The Director of Nursing is to further implement and maintain this assessment among all patient's that may have a wound to improve care for those patients with wounds. This will further be coordinated with the Administrator for the Agency's</p>	

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N 484 Bldg. 00	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record and agency policy review and interview, the home health agency failed to maintain documentation in the clinical record or minutes of case conferences for 3 of 12 (3, 6, and 11) clinical records reviewed with the potential to affect all of the agency's 75 active patients.</p> <p>Findings:</p> <p>1. Clinical record number 6, start of care 4/17/15 and discharge of 10/10/15, included a plan of care established by the patient's physician for the certification</p>	N 484	<p>records. The agency's administrative records will reflect the ongoing Quality Assurance program and the report of the evaluation will be presented on a quarterly basis, by the Administrator, to the professional advisory committee to ensure that this deficiency is corrected and will not recur. The Administrator will be responsible for monitoring these corrective actions and compliance maintained.</p> <p>The Administrator, Director of Nursing, and Quality Assurance Nurse have reviewed the rule, 410 IAC 17-12-2(g), that all personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the communication and the results shall be documented in the clinical record or minutes of case conferences, also further reviewing agency policies on Scope of Services and Case Conferences/ Progress Summary. As also the Director of Nursing has indicated that he was</p>	03/06/2015

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	<p>period of 8/15/14 - 10/13/14. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record. Services provided to this patient were skilled nursing, home health aide, and occupational therapy.</p> <p>On 2/5/15 at 1:15 PM, the director of nursing indicated the lack of case conference / communication notes in the record.</p> <p>2. Clinical record number 11, start of care 8/9/14, included a plan of care established by the patient's physician for the certification period 1/7/14 - 2/4/15. The record failed to evidence minutes of case conferences or documentation of coordination of patient care. Services provided to the patient were skilled nursing and home health aide services.</p> <p>On 2/9/15 at 1 PM, the administrator indicated she had written scratch notes somewhere but these were not in the clinical record at this time.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and</p>		<p>educating the staff the importance of documenting communication notes in the patient's record. The Director of Nursing has also discussed with those employees in clinical record findings that were observed during the survey. The Director of Nursing is to in-service agency staff on 03/06/2015, and to reinforce the importance of case conferences and documenting in the clinical record reinforce especially in multidisciplinary clinical records. The Director of Nursing will further demonstrate how to document this in the clinical record. Further discussing that case conferences will be held at the start of care and at least every 60 days to review and discuss multidisciplinary cases and as needed if there is a change in the patient's status that requires a change in the patient's care plan. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions, to ensure this deficiency is corrected and will not recur. All findings will be reported to the Director of Nursing, who is responsible that the deficiency has been corrected and compliance maintained.</p>		

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N 522 Bldg. 00	<p>include coordination of services."</p> <p>4. The agency policy titled "Case conference / Progress Summary" with a revised date of May 2010 stated, "Case conferences will be held at the start of care and at least every 60 days to review and discuss multidisciplinary cases."</p> <p>5. On 2/9/15 at 2:35 PM, the director of nursing indicated care communication notes were missing from the clinical records and he was educating the staff on including care communication notes in the records.</p> <p>6. Clinical record #3 (SOC 1/12/15, Certification Period 1/12/15-3/12/15) failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record. Services provided to this patient were skilled nursing and home health aide.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, observation, and interview, the</p>	N 522	The Administrator, Director of Nursing, Quality Assurance Nurse reviewed the Rule, 410 IAC	03/06/2015

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	<p>agency failed to ensure plans of care were ordered by and reviewed by physicians to continue home care services and followed by the registered nurse and home health aides providing services for 7 of 12 records reviewed (2, 3, 4, 5, 6, 9, and 12).</p> <p>Findings</p> <p>1. Clinical record #5, start of care (SOC) 10/14/15 and a diagnosis of dementia, included a plan of care for the certification period of 12/29/14 - 2/26/15. This plan of care included an extra visit made by the HHA on 1/6/15. HHA visits were ordered on the plan of care for 1 visit a week x 5 weeks. There were visits on 1/4/15 and 1/7/15 with HHA.</p> <p>On 2/4/15 at 3:50 PM, the administrator stated, "I forgot I told her to make an extra visit.</p> <p>2. At a home visit observation on 2/5/15 at 10 AM, Employee G, Registered Nurse, failed to complete a total physical assessment with patient #6. The patient's feet were not examined. No pedal pulses were assessed. The skilled nurse filled the patient's medication reminder box for a week. The patient did not fill the medication box.</p>		<p>17-13-1(a), Patient Care, that medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist, or podiatrist;further review agency policies on Scope of Services, Ongoing Assessments, and Home Health Aide Job Description. Professional nursing services are to be provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include initial and ongoing comprehensive assessments, as well as OASIS assessments that are due; initiating plan of care and revising as necessary; preparing clinical any progress notes; coordination of services;referrals; informing MD and other staff of changes in patient's needs.Physician services are provided by licensed Doctor of Medicine, Osteopathy and Podiatry and include among others – developing and /or authorizing the plan of care, approving additions/modifications to original plan of care and signing such documents in accordance with the required time frame. Clinical record #9, SOC 12/13/14, certification period 12/13/14-2/10/15, had no visit observed during the week of 12/14/15 – 12/20/14 during survey,after discussing with clinical record #9's skilled nurse there was a missed visit for that week (See Attachment 1).</p>	

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	<p>a. Clinical record #6, the active record of patient #6 with a principal diagnosis of rheumatoid arthritis and SOC date of 1/12/14, included a plan of care for the certification period of 1/12/15 - 3/12/15. This plan of care stated, "Skilled nurse to assess patient's physical and mental status ... SN to focus physical assessment to cardiovascular status noting baseline vital signs and changes over episode and s/s [signs and symptoms] of edema ... SN[skilled nursing] to assess patient filling medication box to determine if patient is preparing correctly."</p> <p>b. On 2/5/15 at 10:30 AM, Employee G indicated not assessing the patient's feet or the patient's pedal pulses on the feet or checking for edema on the lower extremities at the visit. She also indicated filling the patient's medication weekly reminder box for the next week.</p> <p>c. On 2/9/15 at 3:50 PM, the administrator was asked if Employee G followed the plan of care with the lack of assessment of the patient's feet at this visit on 2/5/15 at 10 AM. The administrator did not answer and shrugged her shoulders.</p> <p>d. This was a previous discharged record for Clinical record #6.</p>		<p>Clinical record #12, SOC 5/8/14, multiple certification periods not signed within time frame, it has been discussed during the survey that these plans of care have been sent and notified to the physician, but not received back with physician signature in a timely. Agency has attempted multiple times to check for status of patient's plan of care with physician's signature, and physician's staff repeatedly replied, "Documents are in process." Agency is to work closely and follow up with physician's office to obtain signed plans of care (See Attachment 2). Ongoing assessments provide guidelines for assessments of patients during ongoing care. The scope and intensity of ongoing assessments will be determined by the patient's diagnoses, condition, desire for care, response to previous care and the care setting. During each home visit the appropriate clinician will re-evaluate the patient according to the problems identified during the initial visit. Based on each assessment, the plan of care problems, needs, goals and outcomes will be reviewed and revised, according to the clinician. Based on the findings of the reassessment, written/verbal orders will be generated and forwarded to the physician as needed. The Administrator, Director of</p>	

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	<p>Clinical record #6, start of care 4/17/14 and discharge of 10/10/14, included a plan of care for the certification period of 8/15/14 - 10/13/14. This plan of care was not signed by the physician until 10/13/14. Nursing visits were made on 10/2/14 and 10/10/14. home health aide (HHA) visits were made on 8/15/14, 8/19/14, 8/22/14, 8/26/14, 8/29/14, 9/2/14, 9/5/14, 9/9/14, 9/12/14, 9/16/14, 9/19/14, 9/23/14, 9/26/14, 9/29/14, 10/3/14, 10/6/14, 10/10/14. occupational Therapy (OT) visits were made on 8/15/14, 8/18/14, 8/22/14, 8/27/14, 8/29/14, 9/5/14, and 9/6/14.</p> <p>e. On 2/5/15 at 4:45 PM, the administrator indicated the plan of care was not signed in a timely manner.</p> <p>3. Clinical record # 9, start of care 12/13/14 and diagnosis of post traumatic seizures, included a plan of care for the certification period of 12/13/14 - 2/10/15 with skilled nursing ordered 1 times a week X 9 weeks. There was no visit for the week of 12 / 14 /15 - 12/20/14.</p> <p>On 2/3/15 at 2:15 PM, the administrator did not respond to why there was no nursing visit the week of 12/14/15 - 12/20/14 when asked why the nursing visit had not occurred.</p>		<p>Nursing, and Quality Assurance Nurse will in-service agency staff on March 06, 2015 to ensure all services provided follow a written order signed by a physician, as well as the written plan of care established reviewed and signed by a physician. Staff have been directed that any changes in the POC, need to be viewed and signed by the physician in a timely manner. Reinforcement of provided services will be in accordance with plan of care and documented. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions, to ensure this deficiency is corrected and will not recur. All findings will be reported to the Director of Nursing who is responsible that the deficiency has been corrected and compliance maintained.</p>	

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	<p>4. Clinical record # 12, start of care 5/8/14 and diagnosis of open wound of breast, included a plans of care that were not signed in a timely manner by the physician.</p> <p>a. The clinical record included a plan of care for the certification period of 7/7/14 - 9/4/14. This plan of care was not signed by the physician until 8/31/14. A recertification visit occurred with the RN on 9/3/14.</p> <p>b. The clinical record included a plan of care for the certification period of 9/5/14 - 11/3/14. This plan of care was not signed by the physician until 2/4/15. Another physician, not the attending physician, had signed this plan of care. A recertification visit with the RN occurred on 10/31/14. Other SN visits occurred on 10/2/14, 10/7/14, 10/25/14,</p> <p>c. The clinical record included a plan of care for the certification period of 11/4/14 - 1/2/15. This plan of care was not signed by the physician. The skilled nurse visited on 12/12/14, 12/16/14, 12/20/14, 12/26/14, 1/2/15. The home health aide visited on 12/24/14, 12/30/14, 12/31/14, 1/2/15.</p> <p>d. The clinical record included a plan of care for the certification period of</p>			

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	<p>1/3/15 - 3/3/15. Skilled nurse visits had been made on 1/5/15, 1/12/15, 1/19/15, 1/27/15. HHA visits were made on 1/6/15, 1/7/15, 1/13/15, 1/14/15, 1/20/15, 1/21/15, 1/27/15, and 1/28/15.</p> <p>e. On 2/9/15 at 3:50 PM, the administrator indicated the plans of care had not been signed within the agency policy.</p> <p>5. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse."</p> <p>6. Home visit observation made on 2/4/15 at 4:00 PM to patient #2 with Employee B, Director of Nursing. During this visit the patient's pedal pulse was not assessed and the patient's weight was not taken.</p> <p>A. Clinical Record #2's (SOC 1/12/15, Certification Period 1/12/15-3/12/15), included a plan of care that states, "... SN is to focus physical assessment to cardiovascular status ... SN to perform weekly weight ... ". No weights were recorded in the patients chart during SN visits for the duration of service.</p>				

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	<p>B. Interview on 2/9/2015 at 2:55 PM, the Administrator and DON agreed that patient #2's weight should have been taken at the home visit observation and weekly at previous SN visits and pedal pulse should have been assessed as part of the total physical and focused cardiovascular assessment.</p> <p>7. Home visit observation made on 2/5/15 at 9:30 AM to patient #3 (SOC 11/7/14, Certification Period 1/6/15-3/6/15) with employee H, Registered Nurse. During this visit the RN did not cleanse the wound to the patient's lower back with normal saline, only cleansed the area with baby wipes that were being used to remove stool from patient.</p> <p>A. The patient's plan of care states, " ... SN to perform/instruct on wound care as follows: Cleanse stage 1 pressure ulcer to lower back with 0.9% NS ... "</p> <p>B. The patient's plan of care states, " ... SN to inform physician if ... symptomatic heart rate greater than 100 or less than 60 beats/min ... ." On SN visit notes of 1/22/15 pulse 59, 1/15/15 pulse 57, 1/9/15 pulse 59, the physician was not informed of the out of range</p>			

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	<p>heart rates.</p> <p>C. Interview on 2/6/2015 at 2:15 PM, the Administrator and DON agreed that the RN, employee H, should have followed the plan of care by cleaning the wound to patient #3's lower back with 0.9% NS.</p> <p>D. Interview on 2/9/2015 at 2:45 PM, The Administrator and DON agreed that the RN, employee H, should have followed the plan of care by informing the physician of the patients out of range heart rates as stated in the plan of care.</p> <p>8. Clinical Record #4 (SOC 9/2/14, Certification Period 12/31/14-2/28/15), included a plan of care that states, " ... SN to perform weekly weight ... ." No weights were recorded in the patients chart during SN visits for the duration of service.</p> <p>Clinical Record #4 included a plan of care that states, " ... SN to perform weekly weight ... ." No weights were recorded in the patients chart during SN visits for the duration of service.</p> <p>9. The agency's policy titled "Ongoing Assessments", dated May 2010, states, "Purpose: To provide guidelines for assessments of patients during ongoing care ... 2. Using the standards of care</p>			

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	<p>identified by the organization, the clinician will reassess the patient for: ... B. Weight (once each week, if indicated by disease process) ... ."</p> <p>Regarding following the plan of care</p> <p>10. During a home visit observation on 2/5/15 at 11:00 AM to patient #4 with employee C, Home Health Aide, the aide was observed giving the patient a bath, pericare, taking vitals, skin care, nail care, and assist with dressing which did not include all care listed on the aide assignment sheet.</p> <p>11. Clinical Record Review on 2/6/15 at 1:58 PM of patient #4's clinical record (SOC 10/30/14, Certification Period 12/29/14-2/26/15), The plan of care states, " ... HA to assist with ADL's &amp; IADL's per HHA care plan ... ." All Aide visit notes completed by employee C in the patients clinical record were not completed as assigned on the Aide assignment sheet.</p> <p>A. Interview on 2/6/15 at 2:05 PM, the agency's administrator agreed that employee C, HHA should follow the aide assignment sheet.</p> <p>12. Home visit observation made on 2/6/15 at 10:30 AM to patient #8, with</p>			

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	<p>employee E, Home Health Aide, was observed giving the patient a bath, pericare, taking vitals, skin care, shampoo, hair care, nail care, side of bed dangle, and assist with dressing, which did not include all care listed on the aide assignment sheet.</p> <p>13. Clinical Record Review on 2/6/15 at 12:45 PM of patient #8's clinical record (SOC 9/2/14, Certification Period 12/31/14-2/28/15), the plan of care states, " ... HA to assist with ADL's &amp; IADL's per HHA care plan ... ." All Aide visit notes completed by employee E in the patients clinical record were not completed as assigned on the Aide assignment sheet.</p> <p>A. Interview on 2/6/15 at 1:45 PM, the agency's administrator agreed that employee E, HHA should follow the aide assignment sheet.</p> <p>14. The agencies policy titled "Home Health VI", dated May 2010, states, "Job Title/Position: Certified home Health Aide ... Job Description Summary ... The home health aide is responsible for observing patients, reporting these observations and care performed ... 1. Providing personal care including: ... C. Oral hygiene D. Shampoos E. Changing bed linen ... I. Keeping patients living</p>			

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N 524 Bldg. 00	<p>area clean and orderly, as appropriate 2. Planning and preparing nutritious meals. 3. Assisting in feeding the patient, if necessary ... 5. Assisting in ambulation and exercise according to the plan of care. 6. Performing range of motion ... ."</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. (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</p>			

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	<p>referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on home visit observation, policy and clinical record review, and interview, the agency failed to ensure the plan of care was signed by the primary care physician (PCP) and included all required elements for 4 of 12 records reviewed (#1, #6, #11, #12) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record # 1, start of care 12/16/14 and diagnosis of unspecified hypertensive heart disease without heart failure, included a plan of care for the certification period of 12/16/14 - 2/13/15. This plan of care failed to include the patient's pacemaker and its location on the patient's left chest and the presence of an electronic medical monitoring device to monitor the pacemaker in the home.</p> <p style="padding-left: 40px;">a. On 2/4/15 at 10 AM, patient #1 indicated having a pacemaker on the left side of the chest and a medical monitoring device to electronically evaluate the pacemaker in the home. Patient #1 indicated having these the pacemaker and electronic monitoring device since March of 2014.</p>	N 524	<p>The Administrator, Director of Nursing, and Quality Assurance Nurse reviewed the rule 410 IAC 17-13-1(a) (1) Patient Care and agency policies on Scope of Services, Admission Criteria and Process, Care Planning Process, Physician Participation in Plan of Care, and Verification of Physicians Orders. Professional nursing services are to be provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include initial and ongoing comprehensive assessments, as well as OASIS assessments that are due; initiating plan of care and revising as necessary. Physician services are provided by licensed Doctor of Medicine, Osteopathy and Podiatry and include among others – developing and /or authorizing the plan of care, approving additions/modifications to original plan of care and signing such documents in accordance with the required time frame. The agency is to notify physician and/or physician's staff of the patient's plan of care and importance of physician's signature verification to be received back to the agency in a timely manner. The patient must be under the care of a physician. The patient's physician must order and approve the provision</p>	03/06/2015

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NAME OF PROVIDER OR SUPPLIER  ASSURED HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1947 HARDER CT STE B SCHERERVILLE, IN 46375
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	<p>b. On 2/4/15 at 10:05 AM, a cardiac monitoring device for the patient's pacemaker electronic device was noted by the bedside of patient #1.</p> <p>c. On 12/4/14 at 4:10 PM, the administrator indicated the plan of care failed to show the patient had a pacemaker or a electronic monitoring device for the pacemaker present in the home.</p> <p>2. Clinical record #6, start of care 4/17/14 and discharge of 10/10/14, included a plan of care for the certification period of 8/15/14 - 10/13/14. This plan of care was not signed by the physician until 10/13/14. Nursing visits were made on 10/2/14 and 10/10/14. Home health aide (HHA) visits were made on 8/15/14, 8/19/14, 8/22/14, 8/26/14, 8/29/14, 9/2//14, 9/5/14, 9/9/14, 9/12/14, 9/16/14, 9/19/14, 9/23/14, 9/26/14, 9/29/14, 10/3/14, 10/6/14, 10/10/14. OT visits were made on 8/15/14, 8/18/14, 8/22/14, 8/27/14, 8/29/14, 9/5/14, and 9/6/14.</p> <p>On 2/5/15 at 4:45 PM, the administrator indicated the plan of care was not signed in a timely manner.</p> <p>2. Clinical record #11, start of care date 8/9/14 and a primary diagnosis of</p>		<p>of any service. The initial assessment must be performed within 48 hours of the referral, or patient's return home, or on the start of care date ordered by the physician. At the time of the initial assessment the clinician will develop the patient plan of care based upon the patient's identified needs and will review it with the patient and family/caregiver. A written plan of care will be initiated within 5 days of start of care and updated at least every 60 days. The comprehensive assessment must be updated and revised every 60 days beginning with the start of care. Documentation in the clinical record should support the assessment as well as the actions taken in response. Clinical record #1, SOC 12/16/14, certification 12/16/14-2/13/15: After review of the plan of care for clinical record #1 the Director of Nursing reviewed the patient's plan of care with the patient's nurse and adjusted the plan of care to include the patient's pacemaker, assessments, and electronic medical monitoring device (See Attachment 4) The Administrator, Director of Nursing and Quality Assurance Nurse will in-service all agency staff on Friday, March 6, 2015, to ensure that all services are provided, in accordance, with the patient's plan of care, and to include initial and ongoing assessments of patient's needs. Reinforcement of</p>	

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	<p>unspecified hypertensive heart disease with heart failure, included a plan of care for the certification period of 12/27/14 - 2/4/15. The patient was still on service and did not have a recertification assessment for the next recertification period completed. There was no plan of care for the new certification period.</p> <p>On 2/10/15 at 12:35 PM, the administrator indicated the patient was still on service and did not have a current plan of care.</p> <p>3. Clinical record # 12, start of care 5/8/14 and diagnosis of open wound of breast, included a plans of care that were not signed in a timely manner by the physician.</p> <p>a. The clinical record included a plan of care for the certification period of 7/7/14 - 9/4/14. This plan of care was not signed by the physician until 8/31/14. A recertification visit occurred with the registered nurse (RN) on 9/3/14.</p> <p>b. The clinical record included a plan of care for the certification period of 9/5/14 - 11/3/14. This plan of care was not signed by the physician until 2/4/15. Another physician, not the attending physician, had signed this plan of care. A recertification visit with the RN occurred</p>		<p>comprehensive OASIS assessments and completion of such assessments, at appropriate points in patient care, will be addressed. Initial assessments to be completed within 48 hours and the Plan of Care initiated within 5 days. Agency staff will also be in-serviced on notifying physicians of patient's Plan of Care and receiving the Plan of Care with physician's signature verification in a timely manner and to follow-up with physician and the physician's staff, if physician's signature is still required. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions, to ensure this deficiency is corrected and will not recur. All findings will be reported to the Director of Nursing, who is responsible that the deficiency has been corrected and compliance maintained.</p>				

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	<p>on 10/31/14. Other skilled nurse (SN) visits occurred on 10/2/14, 10/7/14, 10/25/14,</p> <p>c. The clinical record included a plan of care for the certification period of 11/4/14 - 1/2/15. This plan of care was not signed by the physician. The skilled nurse visited on 12/12/14, 12/16/14, 12/20/14, 12/26/14, 1/2/15. The home health aide visited on 12/24/14, 12/30/14, 12/31/14, 1/2/15.</p> <p>d. On 2/9/15 at 3:50 PM, the administrator indicated the plans of care had not been signed timely.</p> <p>4. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include: initial and ongoing assessments of the patient's needs, including OASIS assessments at appropriate points in time ... initiating the plan of care and revising as necessary ... physician services are provided by the licensed Doctor of Medicine, Osteopathy, and Podiatrist and include ... developing and / or authorizing the plan of care ... submitting signed orders for plans of care and changes in accordance with required time frames."</p>			

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	<p>5. The agency policy titled "Admission Criteria and Process" with a revised date of May 2010 stated, "The patient must be under the care of a physician. The patient's physician ... must order and approve the provision of any service ... The initial assessment must be performed within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician."</p> <p>6. The agency policy titled "Care Planning Process" with a revised date of May 2010 stated, "A written plan of care will be initiated within 5 days of start of care and updated at least every 60 days or as the patient's condition warrants ... the clinical plan of care includes ... supplies and equipment required ... at the time of the initial assessment, the clinician ... will develop the patient plan of care based upon the patient's identified needs and will review it with the patient and family / caregiver ... all clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, including but not limited to ... A. individualized patient needs and resultant problems related to care, functional status, and family / caregiver support system ... patient treatment choices ... based on the assessment and conclusions,</p>			

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	<p>the plan of care will include, but will not be limited to A. identified patient problems and needs ... equipment and supplies ... the plan of care will be based upon the physician's ... orders and will encompass the equipment, supplies, and services required to meet the patient's needs ... the clinicians will be responsible to revise the plan of care or update the plan at least every 60 days."</p> <p>7 The agency policy titled "Physician Participation in plan of care" with a revised date of May 2010 stated, "A physician will direct the care of every home health care patient admitted for service ... The attending physician will participate in the care planning process by initiating, reviewing and revising therapeutic and diagnostic orders ... the attending physician's verbal certification will be obtained at the time the plan of care is established. 3. The attending physician will certify the need for the home health care services by signing the plan of care / treatment within 30 days of the start of care. 4. The attending physician's recertification will be obtained in intervals of at least every 60 days when the patient's plan of care is reviewed, the patient is recertified, and more often, if warranted."</p> <p>8. The agency policy titled "Verification</p>				

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N 537 Bldg. 00	<p>of Physician Orders" with a revised date of May 2010 stated, "to ensure that accurate physician ... orders are obtained in accordance with applicable law and regulation ... Orders will be documented on a form provided by Assured Home Healthcare, inc. dated and signed by the professional receiving the order."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on clinical record review, policy review, observation, and interview, the agency failed to ensure skilled nursing services followed the plan of care for 4 of 12 records reviewed (2, 3, 4, and 9 ).</p> <p>Findings</p> <p>1. At a home visit observation on 2/5/15 at 10 AM, Employee G, Registered</p>	N 537	The Administrator, Director of Nursing, and Quality Assurance Nurse reviewed the rule 410 IAC 17-14-1(a), and the agency policies: Scope of Services and Ongoing Assessments. The Director of Nursing and Quality Assurance Nurse is to in-service skilled nursing staff, on Friday, March 6, 2015, to discuss the rule and agency policies and the importance of nursing services to follow the scope of services, in accordance with the patient's	03/06/2015

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	<p>Nurse, failed to complete a total physical assessment with patient #6. The patient's feet were not examined. No pedal pulses were assessed. The skilled nurse filled the patient's medication reminder box for a week. The patient did not fill the medication box.</p> <p>a. Clinical record #6, the active record of patient #6 with a principal diagnosis of rheumatoid arthritis and SOC date of 1/12/14, included a plan of care for the certification period of 1/12/15 - 3/12/15. This plan of care stated, "Skilled nurse to assess patient's physical and mental status ... SN to focus physical assessment to cardiovascular status noting baseline vital signs and changes over episode and s/s [signs and symptoms] of edema ... SN [skilled nursing] to assess patient filling medication box to determine if patient is preparing correctly."</p> <p>b. On 2/5/15 at 10:30 AM, Employee G indicated not assessing the patient's feet or the patient's pedal pulses on the feet or checking for edema on the lower extremities at the visit. She also indicated filling the patient's medication weekly reminder box for the next week.</p> <p>c. On 2/9/15 at 3:50 PM, the administrator was asked if Employee G</p>		<p>medical plan of care and on-going assessments with patient visits by the skilled nursing staff. Clinical record #9, SOC 12/13/14, certification period 12/13/14-2/10/15, had no visit observed during the week of 12/14/15 – 12/20/14 during survey, after discussing with clinical record #9's skilled nurse there was a missed visit for that week (See Attachment 1). The Quality Assurance Nurse will audit 10% of clinical records, quarterly through 02-2016, to ensure skilled nursing services are providing patient care that is in accordance with the patient's medical plan of care, following physician's written orders, frequency of visits, and ongoing assessments, and reporting all findings to the Director of Nursing and/or Administrator, whom are responsible that the deficiency has been corrected and compliance maintained.</p>	

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	<p>followed the plan of care with the lack of assessment of the patient's feet at this visit on 2/5/15 at 10 AM. The administrator did not answer and shrugged her shoulders.</p> <p>2. Clinical record # 9, start of care 12/13/14 and diagnosis of post traumatic seizures, included a plan of care for the certification period of 12/13/14 - 2/10/15 with skilled nursing ordered 1 times a week X 9 weeks. There was no visit for the week of 12 / 14/15 - 12/20/14.</p> <p>On 2/3/15 at 2:15 PM, the administrator did not respond to why there was no nursing visit the week of 12/14/15 - 12/20/14 when asked why the nursing visit had not occurred.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse."</p> <p>4. Home visit observation made on 2/4/15 at 4:00 PM to patient #2 with Employee B, Director of Nursing. During this visit the patient's pedal pulse was not assessed and the patient's weight was not taken.</p>			

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	<p>A. Clinical Record #2's (SOC 1/12/15, Certification Period 1/12/15-3/12/15), included a plan of care that states, " ... SN is to focus physical assessment to cardiovascular status ... SN to perform weekly weight ... ". No weights were recorded in the patients chart during SN visits for the duration of service.</p> <p>B. Interview on 2/9/2015 at 2:55 PM, the Administrator and DON agreed that patient #2's weight should have been taken at the home visit observation and weekly at previous SN visits and pedal pulse should have been assessed as part of the total physical and focused cardiovascular assessment.</p> <p>5. Home visit observation made on 2/5/15 at 9:30 AM to patient #3 (SOC 11/7/14, Certification Period 1/6/15-3/6/15) with employee H, Registered Nurse. During this visit the RN did not cleanse the wound to the patient's lower back with normal saline, only cleansed the area with baby wipes that were being used to remove stool from patient.</p> <p>A. The patient's plan of care states, " ... SN to perform/instruct on wound care</p>			
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	<p>as follows: Cleanse stage 1 pressure ulcer to lower back with 0.9% NS ... "</p> <p>B. The patient's plan of care states, " ... SN to inform physician if ... symptomatic heart rate greater than 100 or less than 60 beats/min ... ." On SN visit notes of 1/22/15 pulse 59, 1/15/15 pulse 57, 1/9/15 pulse 59, the physician was not informed of the out of range heart rates.</p> <p>C. Interview on 2/6/2015 at 2:15 PM, the Administrator and DON agreed that the RN, employee H, should have followed the plan of care by cleaning the wound to patient #3's lower back with 0.9% NS.</p> <p>D. Interview on 2/9/2015 at 2:45 PM, The Administrator and DON agreed that the RN, employee H, should have followed the plan of care by informing the physician of the patients out of range heart rates as stated in the plan of care.</p> <p>6. Clinical Record #4 (SOC 9/2/14, Certification Period 12/31/14-2/28/15), included a plan of care that states, " ... SN to perform weekly weight ... ." No weights were recorded in the patient's chart during SN visits for the duration of service.</p>			

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N 540 Bldg. 00	<p>Clinical Record #4 included a plan of care that states, " ... SN to perform weekly weight ... ." No weights were recorded in the patients chart during SN visits for the duration of service.</p> <p>7. The agency's policy titled "Ongoing Assessments", dated May 2010, states, "Purpose: To provide guidelines for assessments of patients during ongoing care ... 2. Using the standards of care identified by the organization, the clinician will reassess the patient for: ... B. Weight (once each week, if indicated by disease process) ... ."</p> <p>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. Based on home visit observation, policy and clinical record review, and interview, the agency failed to ensure the registered nurse had completed the initial</p>	N 540	The Administrator, Director of Nursing, and Quality Assurance Nurse reviewed the Rule, 410 IAC 17-14-1(a) (1) (A), and the agency policies on Scope of Services and Initial and	03/06/2015

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	<p>/ comprehensive assessment for 2 of 12 records reviewed (#1 and #9).</p> <p>Findings</p> <p>1. Clinical record # 1, start of care 12/16/14 and diagnosis of unspecified hypertensive heart disease without heart failure, evidenced an initial / comprehensive assessment was completed on 12/16/14 that lacked a physical assessment of the location of the pacemaker on the patient and lacked documentation concerning a medical monitoring device for the electronic monitoring of the pacemaker was present in the home at the bedside of the patient. Employee R, Registered Nurse, had completed this assessment on 12/16/14.</p> <p>a. On 2/4/15 at 10 AM, patient #1 indicated having a pacemaker on the left side of the chest and a medical monitoring device to electronically evaluate the pacemaker in the home. Patient #1 indicated having the pacemaker and electronic monitoring device since March of 2014.</p> <p>b. On 2/4/15 at 10:05 AM, an cardiac monitoring device for the patient's pacemaker electronic device was noted by the bedside of patient #1.</p>		<p>Comprehensive Assessment. Clinical record #1, SOC 12/16/14 After review of the plan of care for clinical record #1 the Director of Nursing reviewed the patient's plan of care with the patient's nurse and adjusted the plan of care to include the patient's pacemaker, assessments, and electronic medical monitoring device (See Attachment 4). Clinical record # 9, SOC 12/13/14 After review of the plan of care for clinical record #9, the Director of Nursing reviewed the patient's plan of care with the patient's nurse reinforcing the compliance of following the plan of care and the importance of a comprehensive assessment. Employee verbalized understanding. The Director of Nursing and the Quality Assurance Nurse will in-service, on Friday, March 6, 2015, to the skilled nursing staff to discuss the rule and agency's policy on Scope of Services and Initial and Comprehensive Assessment and importance of the initial evaluation visit by the registered nurse. The Quality Assurance Nurse will audit 10% of clinical records quarterly through 02-2016 for compliance and to monitor these corrective actions, to ensure this deficiency is corrected and will not recur. All findings will be reported to the Director of Nursing.</p>		

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	<p>c. On 2/4/15 at 4:10 PM, the administrator indicated the comprehensive assessment failed to show the patient had a pacemaker or a electronic monitoring device for the pacemaker present in the home.</p> <p>2. Clinical record # 9, start of care 12/13/14 and diagnosis of post traumatic seizures, evidenced an initial start of care / comprehensive assessment was completed on 12/13/14 that was incomplete. The assessment failed to evidence the nurse had assessed the patient's temperature and respirations at the start of care visit.</p> <p>On 2/3/15 at 2:15 PM, the administrator indicated the initial / start of care assessment was not complete.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include: initial and ongoing assessments of the patient's needs, including OASIS assessments at appropriate points in time ... initiating the plan of care and revising as necessary."</p> <p>4. The agency policy titled "Initial and</p>			

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N 541 Bldg. 00	<p>comprehensive assessment" with a revised date of May 2010 stated, "An initial assessment will be performed and documented in the patient's clinical record by a registered nurse ... the initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician, or at the patient / family request with the approval of the physician ... a comprehensive patient assessment will be completed within 5 calendar days of the patient' start of care ... the assessment will be patient specific and comprehensive to include the patient's need for home care ... a physical assessment, including blood pressure, temperature, respiration, skin, pain status ... and other relevant data related to pertinent physical status ... equipment presently in the home and potentially needed by the patient."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on policy review, clinical record</p>	N 541	The Administrator, Director of Nursing, and Quality Assurance Nurse reviewed the Rule, 410	03/06/2015

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	<p>review, and interview, the agency failed to ensure the registered nurse reevaluated the patient's needs at time of recertification for 2 of 6 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days (#11 and #12).</p> <p>Findings</p> <p>1. Clinical record #11, start of care 8/9/14 and a primary diagnosis of unspecified hypertensive heart disease with heart failure, included a plan of care for the certification period of 12/27/14 - 2/4/15. The patient was still on service and did not have a recertification assessment completed during the last 5 days of the prior certification period.</p> <p>On 2/10/15 at 12:35 PM, the administrator indicated the patient was still on service and had not had a recertification assessment completed by the registered nurse.</p> <p>2. Clinical record #12, start of care date 5/8/14 and diagnosis of open wound of the breast, included plans of care for the certification periods of 11/4/14 - 1/2/15 and 1/3/15 - 3/3/15. The registered nurse who visited the patient on 1/2/15 did not complete the oasis recertification</p>		<p>IAC 17-14-1(a)(1)(B), and the agency policies on Scope of Services, Reassessment/ Recertification, and Admission Criteria &amp; Process. The Administrator provided an in-service on March 06, 2015 to the skilled nursing staff to discuss the agency's policy of the Scope of Services and Reassessment/ Recertification and Admission Criteria &amp; Process especially the regularly re-evaluation of the patient's nursing needs. Clinical record #11, SOC 8/9/14, certification 12/27/14-2/4/15: After review of the plan of care for clinical record #11, the Director of Nursing reviewed the patient's plan of care with the patient's nurse reinforcing the compliance of following the plan of care and the importance of a completing a comprehensive assessment every 60 days. Employee verbalized understanding. Clinical record #12, SOC 5/8/14, certification 11/4/14-1/2/15 and 1/3/15-3/3/15: After review of the plan of care for clinical record #12, the Director of Nursing reviewed the patient's plan of care with the patient's nurse reinforcing the compliance of following the plan of care and the importance of a completing a comprehensive assessment within the five day window, every 60 days. Employee verbalized understanding. The Quality Assurance Nurse will audit 10% of clinical records quarterly</p>		

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	<p>assessment on 1/2/15. The record failed to evidence the registered nurse had completed the recertification assessment during the 5 day window. The administrator completed the oasis assessment without visiting the patient. The clinical record evidenced a skilled nursing visit by Employee J on 1/2/15 and an oasis document completed by the administrator on the same day. The pain assessment had not been completed for this visit on the assessment.</p> <p>A. On 1/9/15 at 3:45 PM, Employee M, Registered Nurse, indicated visiting the patient on 1/2/15. An oasis assessment was not completed.</p> <p>B. On 1/9/15 at 3:45 PM, the administrator indicated completing the oasis transmission by discussing the visit with the RN, Employee M The administrator indicated the pain assessment was not complete for this assessment.</p> <p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include: initial and ongoing assessments of the patient's needs, including OASIS</p>		through 02-2016 for compliance and to monitor these corrective actions, to ensure this deficiency is corrected and will not recur. All findings will be reported to the Director of Nursing, who is responsible that the deficiency has been corrected and compliance maintained.				

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N 542 Bldg. 00	<p>assessments at appropriate points in time ... initiating the plan of care and revising as necessary ... physician services are provided by the licensed Doctor of Medicine, Osteopathy, and Podiatrist and include ... developing and / or authorizing the plan of care ... submitting signed orders for plans of care and changes in accordance with required time frames."</p> <p>4. The agency policy titled "Reassessment / Recertification" with a revised date of May 2010 stated, "The comprehensive assessment must be updated and revised every 60 days beginning with the start of care ... documentation in the clinical record should support the assessment as well as the actions taken in response."</p> <p>5. The agency policy titled "Admission Criteria and Process" with a revised date of May 2010 stated, "The patient must be under the care of a physician. The patient's physician ... must order and approve the provision of any service ... The initial assessment must be performed within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician."</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where</p>			

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	<p>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> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the registered nurse completed a recertification comprehensive assessment for 2 of 6 active records reviewed of patients receiving services for over 60 days with the potential to affect all patients receiving services longer than 60 days (#11 and #12).</p> <p>Findings</p> <p>1. Clinical record #11, start of care date 8/9/14 and a primary diagnosis of unspecified hypertensive heart disease with heart failure, included a plan of care for the certification period of 12/27/14 - 2/4/15. The patient was still on service and did not have a recertification assessment for the next recertification period completed. There was no plan of care either.</p> <p>On 2/10/15 at 12:35 PM, the administrator indicated the patient was still on service and had not had a recertification assessment completed by the registered nurse.</p>	N 542	<p>The Administrator, Director of Nursing, and Quality Assurance Nurse reviewed the Rule, 410 IAC 17-14-1(a)(1)(C), Scope of Services, and the agency policies on Scope of Services and Reassessment/ Recertification. The Administrator provided an in-service to the skilled nursing staff on March 6, 2015 to discuss the agency's policy of the "Scope of Services" and "Reassessment/ Recertification" and especially the registered nurse to initiate the plan of care and necessary revisions. Clinical record #11, SOC 8/9/14, certification 12/27/14-2/4/15: After review of the plan of care for clinical record #11, the Director of Nursing reviewed the patient's plan of care with the patient's nurse reinforcing the compliance of recertification reassessment and following a plan of care. Employee verbalized understanding. Clinical record #12, SOC 5/8/14, certification 11/4/14-1/2/15 and 1/3/15-3/3/15: After review of the plan of care for clinical record #12, the Director of Nursing reviewed the patient's plan of care with the patient's nurse reinforcing the compliance of following the plan of care and the importance of a completing a</p>	03/06/2015

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	<p>2. Clinical record #12, start of care date 5/8/14 and diagnosis of open wound of the breast, included plans of care for the certification periods of 11/4/14 - 1/2/15 and 1/3/15 - 3/3/15. The registered nurse who visited the patient on 1/2/15 did not complete the oasis recertification assessment on 1/2/15. There was no recertification assessment completed by the visiting RN. The administrator completed the oasis assessment without visiting the patient. The clinical record evidenced a skilled nursing visit by Employee JT on 1/2/15 and an oasis document completed by the administrator on the same day. The pain assessment had not been completed for this visit on the assessment.</p> <p>A. On 1/9/15 at 3:45 PM, Employee M, Registered Nurse, indicated visiting the patient on 1/2/15. An oasis assessment was not completed.</p> <p>B. On 1/9/15 at 3:45 PM, the administrator indicated completing the oasis transmission by discussing the visit with the RN, Employee M The administrator indicated the pain assessment was not complete for this assessment.</p>		<p>comprehensive assessment within the five day window, every 60 days. Employee verbalized understanding (See Attachment 2). The Quality Assurance Nurse is to audit 10% of clinical records quarterly to ensure services provided by the field skilled nursing personnel are in accordance with the patient's medical plan of care signed by the physician's with frequency of visits of all disciplines, reporting all finding to the Director of Nursing and /or Administrator, whom are responsible that the deficiency has been corrected and compliance maintained. The Director of Nursing and the Quality Assurance Nurse will monitor compliance to ensure deficiency will be corrected and will not recur.</p>				

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	<p>3. The agency policy titled "Scope of Services" with a revised date of May 2010 stated, "Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include: initial and ongoing assessments of the patient's needs, including OASIS assessments at appropriate points in time ... initiating the plan of care and revising as necessary ... physician services are provided by the licensed Doctor of Medicine, Osteopathy, and Podiatrist and include ... developing and / or authorizing the plan of care ... submitting signed orders for plans of care and changes in accordance with required time frames."</p> <p>4. The agency policy titled "Reassessment / Recertification" with a revised date of May 2010 stated, "The comprehensive assessment must be updated and revised every 60 days beginning with the start of care ... documentation in the clinical record should support the assessment as well as the actions taken in response."</p>			