

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2014
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NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
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G000000	<p>This visit was a home health federal re-certification survey that resulted in an extended survey on 1/2/14.</p> <p>Survey dates: December 30 and 31, 2013, and January 2, 3, and 8, 2014</p> <p>Facility #005352</p> <p>Medicaid Vendor: # 100265450A</p> <p>Surveyors: Bridget Boston, RN, PH Nurse Surveyor, Team Leader Shannon Pietraszewski RN, PH Nurse Surveyor, Team Member</p> <p>Census: 173 Home Visits: 6</p> <p>Physicians Homecare Inc.is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 17, 2014, through January 17, 2016, due to being found out of compliance with the Conditions of Participation 42 CFR 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision, 484.30: Skilled Nursing Services, 484.36: Home Health Aide services, and 484.48 Clinical Records.</p>	G000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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G000108	<p>Quality Review: Joyce Elder, MSN, BSN, RN January 17, 2014</p> <p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the patient was advised in advance of care of the type and frequency of services to be provided for 5 of 5 records reviewed which were admitted for services within the 60 days prior to the survey with the potential to affect all patients of the agency. (patients 2, 3, 5, 7 and 8)</p> <p>Findings include:</p> <p>1. The policy titled "Admission Criteria" number 6.2 dated 3/11/13</p>	G000108	1.As of 2/5/14 - The "Estimated Visit Frequency and Cost of Care"form has been revised to "Visit Frequency and Cost of Care". A policy and procedure will be revised to reflect the new form title and the process for documenting the provision of care to be furnished to each patient at the start of care visit. In-services will be provided for all Case Managers, Field Nurses and support staff concerning the purpose and procedure for use of the Visit Frequency and Cost of Care form. A Visit Frequency and Cost of Care form will be completed by the Director of	02/08/2014	

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	<p>states, "Admission Criteria ... The client / caregiver accept the policy for periodic evaluations, which may indicate a change in level of care, frequency of visits."</p> <p>2. Clinical record # 3, start of care 11/19/13, failed to evidence the patient or legal representative was informed of the potential frequency and duration of the skilled nurse and physical and occupational therapy visits and the frequency of the aides visits to be provided.</p> <p>3. Clinical record # 5, start of care 11/26/13, failed to evidence the patient or legal representative was informed of the potential frequency and duration of the skilled nurse visits to be provided.</p> <p>4. Clinical record # 7, start of care 12/12/13, failed to evidence the patient or legal representative was informed of the potential frequency and duration of the skilled nurse and physical and occupational therapy visits and the frequency of the aides visits to be provided.</p> <p>5. Clinical record # 8, start of care 11/5/13, failed to evidence the patient or legal representative was informed of the potential frequency and duration of the</p>		<p>Nursing or designee for each patient currently on service. The Case Managers and Field Nurses will deliver these forms to the current patients on service for written and verbal explanation of frequency of visits. 2. The Visit Frequency and Cost of Care form will be given to the Case Managers with the referral forms by the Director of Nursing when an initial assessment is assigned to the Case Manager. 3.The Medical Records Clerk will check each admission chart for the presence of the signed Visit Frequency and Cost of Care form and refer any non-compliance to the Director of Nursing for follow up. The Director of Nursing or designee will audit all current patient charts for the presence of a Visit Frequency and Cost of Care form.The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.</p>		

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G000113	<p>aide visits to be provided.</p> <p>6. On 1/8/14 at 12 PM, employee B indicated the plan developed with the patient and caregiver should be documented and thought it was on the admission documents.</p> <p>7. During an observation of a home visit on 12/30/13 from 3:00 p.m. to 4:30 p.m., Employee B did not inform the patient 2 in advance about the care to be furnished and the frequency of the visits.</p> <p>Employee A (Director of Nursing) was interviewed on 12/31/13 at 4:00 p.m. Employee A indicated Employee B should have informed the patient about the care to be furnished.</p> <p>484.10(e)(1) PATIENT LIABILITY FOR PAYMENT The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient.</p> <p>Based on observation, clinical record review, agency policy review, and interview, the agency failed to provide the patient in writing the potential payment information that may be</p>	G000113	<p>1. A revised policy and procedure will be written on the use of the new form entitled "Insurance Verification and Cost Estimate". The information will be documented on the Visit Frequency and Cost Of Care</p>	02/08/2014			

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	<p>required before care was initiated for 1 of 1 admissions observed (# 2), for 2 of 5 records reviewed with admissions that occurred within 60 days prior to the survey (# 7 and 8), and for 1 of 1 closed record reviewed (#5) with the potential to affect all patients admitted to the agency.</p> <p>Findings include:</p> <p>1. During a home visit on 12/30/13 at 3:00 p.m., Employee B (Registered Nurse) failed to advise upon admission patient # 2's responsibility for payment of services rendered by the agency that would not be covered by the patient's insurance.</p> <p>a. Employee B was interviewed and indicated the patient's deductible "most likely" had already been met and a new deductible would start on January 1, 2014. Employee B indicated the patient would be on service for a short time due to out of pocket expense.</p> <p>b. Employee A (Director of Nursing), on 12/31/13 at 3:00 p.m., indicated she would normally provide the discharge planner at the hospital with payment information to provide to the patient prior to services being rendered.</p>		<p>form and provided to the patient at the initial assessment per policy. An Insurance Verification and Cost Estimate form will be completed by the Director of Nursing for each patient currently on service. The Case Managers and Field Nurses will deliver these forms to the current patient for written and verbal explanation of cost of care.2. An in-service will be provided for all Case Managers, Field Nurses, and support staff concerning the purpose and procedure for the use of the Insurance Verification and Cost Estimate form and the Visit Frequency and Cost of Care form. 3.The Director of Nursing will monitor for completion of an Insurance Verification and Cost Estimate form by the Director of Nursing and any non-compliance will be forwarded to the Chief Financial Officer for follow up.3. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.</p>				

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	<p>2. A policy titled "Admission Criteria" dated 3/11/13 stated "If it is determined the client meets the admission criteria, the nurse continues the admission procedures of describing the bill of rights, HIPPA, complaint procedure, advance directives, agency information, charges and billing, on-call procedures, and consents "</p> <p>3. A policy titled "Client Consent for Services" dated 8/96 stated, "On the initial visit, the nurse or therapist reads and/or explains the Client Agreement form carefully to the client to make clear the client's liability for payment portion ... The professional assures that the client understands all conditions of the Client Agreement including the consent for services and the liability for those services ... "</p> <p>4. Clinical record # 5, start of care 11/26/13, failed to evidence, prior to the provision of care, the patient or legal representative was informed of the potential cost and payment expected for the provision of the skilled nurse visits to be provided.</p> <p>5. Clinical record # 7, start of care 12/12/13, failed to evidence, prior to the provision of care, the patient or legal</p>						

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G000114	<p>representative was informed of the potential cost and payment expected for the provision of the skilled nurse visits to be provided</p> <p>6. Clinical record # 8, start of care 11/5/13, failed to evidence, prior to the provision of care, the patient or legal representative was informed of the potential cost and payment expected for the provision of the skilled nurse visits to be provided.</p> <p>484.10(e)(1)(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay.</p> <p>Based on observation, clinical record review, agency policy review, and interview, the agency failed to provide the patient in writing the potential payment information that may be required before care was initiated for 1 of 1 admissions observed (# 2), for 2 of 5 records reviewed with admissions that occurred within 60 days prior to the survey (# 7 and 8), and for 1 of 1 closed</p>	G000114	<p>1. As of 2/5/14 The Visit Frequency and Cost Of Care form and policy and procedure will be revised to include verification that the patient was informed orally as well as in writing of the cost of care during the initial assessment. A Visit Frequency and Cost of Care form will be completed by the Director of Nursing for each patient currently on service. The Case Managers and Field Nurses will deliver these forms to the current</p>	02/08/2014			

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	<p>record reviewed (#5) with the potential to affect all patients admitted to the agency.</p> <p>Findings include:</p> <p>1. During a home visit on 12/30/13 at 3:00 p.m., Employee B (Registered Nurse) failed to advise upon admission patient # 2's responsibility for payment of services rendered by the agency that would not be covered by the patient's insurance.</p> <p style="padding-left: 40px;">a. Employee B was interviewed and indicated the patient's deductible "most likely" had already been met and a new deductible would start on January 1, 2014. Employee B indicated the patient would be on service for a short time due to out of pocket expense.</p> <p style="padding-left: 40px;">b. Employee A (Director of Nursing), on 12/31/13 at 3:00 p.m., indicated she would normally provide the discharge planner at the hospital with payment information to provide to the patient prior to services being rendered.</p> <p>2. A policy titled "Admission Criteria" dated 3/11/13 stated "If it is determined the client meets the admission criteria, the nurse continues the admission</p>		<p>patients documenting oral as well as written notification of the cost of care.2. An in-service will be provided for all Case Managers, Field Nurses and support staff concerning the purpose and procedure for the use of the Visit Frequency and Cost of Care form.3. The Director of Nursing will be responsible for checking each admission chart for documentation of oral and written notification of cost of care on the Visit Frequency and Cost of Care form. The Medical Records Clerk will refer any non-compliance to the Director of Nursing for follow up. The Director of Nursing or designee will audit all current patient charts for the presence of Visit Frequency and Cost of Care form documenting oral and written notification of cost of care. Any non-compliance will be discussed with the Casre Manager and the audit results reported to the Quality Care Committee.The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.</p>				

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	<p>procedures of describing the bill of rights, HIPPA, complaint procedure, advance directives, agency information, charges and billing, on-call procedures, and consents "</p> <p>3. A policy titled "Client Consent for Services" dated 8/96 stated, "On the initial visit, the nurse or therapist reads and/or explains the Client Agreement form carefully to the client to make clear the client's liability for payment portion ... The professional assures that the client understands all conditions of the Client Agreement including the consent for services and the liability for those services ... "</p> <p>4. Clinical record # 5, start of care 11/26/13, failed to evidence, prior to the provision of care, the patient or legal representative was informed of the potential cost and payment expected for the provision of the skilled nurse visits to be provided.</p> <p>5. Clinical record # 7, start of care 12/12/13, failed to evidence, prior to the provision of care, the patient or legal representative was informed of the potential cost and payment expected for the provision of the skilled nurse visits to be provided</p>			

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G000121	<p>6. Clinical record # 8, start of care 11/5/13, failed to evidence, prior to the provision of care, the patient or legal representative was informed of the potential cost and payment expected for the provision of the skilled nurse visits to be provided.</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on home visit observation, interview, and review of documents, the agency failed to ensure the registered nurse, employee B, performed tasks following standard universal precautions in 3 of 4 home visit observations of a registered nurse in the provision of skilled procedures with the potential to affect all patients of the agency. (patients 1, 2 and 3)</p> <p>The findings include:</p> <p>1. During a home visit on 12/31/13 at 12:45 PM, employee B, a registered nurse, failed to demonstrate and observe standard universal precautions during the provision of care with patient 3 as follows:</p>			G000121	<p>1. Employee B was counseled concerning utilization of standard universal precautions and an Employee Conference Record has been placed in her employee file. The Infection Control Committee will develop policies and procedures concerning cleaning and disinfection of patient care equipment used in the home and on hand hygiene. Supplies and bags have been ordered for the Case Managers and Field Nurses to ensure compliance. In-Services will be conducted by the Infection Control Committee for the Case Managers and Field Nurses. Supply bag usage, disinfection procedures and hand hygiene will be reviewed. The Private Duty Nurses will receive the revised Infection Control policies and procedures per in-services</p>		02/08/2014

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	<p>A. The employee carried into the home 2 bags, one black cloth like bag that resembled a purse and one plastic disposable bag, and one clipboard which were placed on the floor without a barrier beside the patient's recliner. She failed to complete hand hygiene after entering the home and before rendering any care. The black cloth bag contained a blood pressure cuff, stethoscope, and a standard blue handled utility home scissors that were co-mingled and without barriers between the items or between the items and the inside lining of the bag. The second bag was a plastic grocery bag with individually wrapped gauze and syringes and other wrapped supplies.</p> <p>B. The employee withdrew the blood pressure cuff and a stethoscope from the black bag and placed the cuff on the patient's right wrist. After assessing the patient's blood pressure, she returned the cuff to the cloth bag among the other equipment and did not decontaminate or maintain separate from the other supplies. She then used her stethoscope and placed over clothing on the patients back and chest. Following assessment, she returned the stethoscope to the black bag without decontaminating or maintaining separately from the other supplies.</p>		<p>provided by the Infection Control RN or the Quality Improvement RN with post test to follow. The Home Health Aides will be in-serviced on Universal Precautions by the Contracted RN being hired for the Home Health Aide Competency Program.2. The Case Managers will monitor a patient care visit for each of the Field Nurses. The Case Managers will monitor each other during a patient care visit. A Universal Precaution Competency checklist will be utilized for documentation of these regularly monitored visits and forwarded to the Director of Nursing for review and any needed follow up. These monitoring visits will be completed and quarterly thereafter.3. The Case Managers or Field Nurses will be responsible for observing the Private Duty Nurses during a planned patient care visits and a Universal Precaution Competency checklist will be completed and turned into the Director of Nursing for any needed follow up. The Home Health Aides will be monitored during the supervisory visits and a Universal Precaution Competency checklist completed and turned into the Director of Nursing or designee. Any observed non-compliance will be addressed at the supervisory visit. The Director of Nursing will be responsible for ensuring</p>				

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	C. Then employee donned a pair of blue gloves and obtained the scissors from the black bag, sat on the floor and began to cut the gauze dressing, and removed the dressing from the patient's right foot. Once the dressing was removed, she placed the dressing and the scissors on the floor to her right and then brushed her hair from her face three times with the same gloved hands. She then obtained a basin of water from the home; she washed and dried the patient's right foot and noted the three dark dry scabbed wounds on the patient's little toe and three dry scabbed wounds on the second toe. She then washed and dried the left foot; the skin of the left foot was intact. While wearing the same gloves she dressed the right foot with dry gauze; she had gauze left and returned it to the manufacturer's packaging placed on the floor with the soiled dressing, then applied the patient's footwear. While continuing to wear the same gloves, she picked up the soiled dressing from the floor, the remainder of the unused gauze, and the blue handled scissors. While holding all of these items, she placed the scissors into the black bag without decontamination, the remainder of the dressing she placed with the patient's supplies, and the soiled dressing she disposed of in the trash.		ongoing compliance with this regulation.				

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	<p>Then she removed her gloves; she did not complete hand hygiene and brushed her hair from her face.</p> <p>D. Following the dressing change employee B prepared to administer a vitamin B 12 injection and obtain a blood specimen. She placed a chair beside the patient and sat down and completed hand hygiene. She removed a single dose vial of vitamin B 12 from a plastic Ziploc style bag which contained a prescription label. She removed the manufacturer's seal from the top of the vial exposing the rubber septum, then placed the vial on the fabric arm rest of the patient's recliner. There was no barrier on the arm rest. The patient noted the vial and picked it up and held it. The employee removed a syringe from its manufacturer's sealed package, took the vial from the patient's hand, and again placed the vial in the same location on the arm rest. She then removed the sleeve cover from needle and attempted to puncture the rubber septum; she had not cleansed the top of the vial once the patient had handled the vial. The tip of the needle missed the rubber septum and struck the metal top surrounding the septum, she attempted again and punctured through the rubber septum of the vial and withdrew the contents. She then placed the cap of the</p>						

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	<p>needle on the same arm rest of the patient's recliner without a barrier and inserted the needle back into the cap to cover the needle and the syringe that remained on the arm rest capped. She then donned gloves, opened a alcohol wipe, chose the site for the injection, wiped the area with one wipe from north to south direction, removed the cap from the syringe, and administered the vitamin B 12 to the patient in the right upper extremity.</p> <p>E. She then brushed her hair away from her face with both hands as she continued to wear the same gloves. Her clipboard was on the floor was then moved to her lap. She then retrieved from her black bag on the floor a Ziploc style bag which contained supplies for collecting a blood sample. She emptied the contents from the bag onto her clipboard. She decided which supplies she needed and returned the extra back to the plastic bag and placed it in the black bag. With her right gloved hand, she brushed her hair away from her face, applied the tourniquet to the patient's right arm which was laying on the fabric covered arm rest without a barrier, opened an alcohol wipe and wiped the skin at the right antecubital area once in a downward motion, and then placed the needle into a vein and began to fill three</p>			

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	<p>laboratory tubes with blood. After collecting the blood samples and still wearing the same gloves, she pulled a cell phone from her left pocket, looked at the face, returned it to her pocket, wrote on the labels of the blood samples, returned her pen to her pocket, and secured the samples in a Ziploc style bag. She then removed her gloves; no hand hygiene was completed. She collected and placed trash in a receptacle and left the home without completing hand hygiene and holding the Ziploc bag containing the blood samples.</p> <p>F. An interview was conducted with the employee following the home visit; she indicated that the bag she was carrying was used to carry her supplies for work and indicated she did not have anything to use as a barrier with her. She indicated she would bring a barrier to the home and use if the home was dirty. She indicated she did have alcohol wipes to clean her supplies and that she would clean them before her next visit.</p> <p>G. On 1/8/14 at 11:37 AM, employee B indicated the agency did not have a specific policy(s) and procedure(s) regarding infection control practices the staff were to observe and practice while providing services in the</p>						

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	<p>home. She indicated the agency staff were to follow the infection control guidelines per the Centers for Disease Control and she did observe for breaches of infection control procedures in the home during supervisory visits. There was no documentation to support the agency assessed or monitored for infection control nor was there periodically peer to peer review or observation or refresher labs for the agency staff.</p> <p>H. On 1/8/14 at 12 PM, employee N indicated the agency did not have a written policy or procedure for how the staff were to maintain infection control during the provision of care in the patient's home; she indicated she hired professionals.</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact</p>				

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	<p>with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, non-intact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. On 12/30/13 at 12:05 p.m., Employee B was observed to had placed her work bag and clip board on Patient # 1's couch without a barrier.</p>			

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	<p>A. Employee B was observed to remove the blood pressure cuff, thermometer, pulse oximeter, and stethoscope from the work bag, use them, and replace the items in the work bag without cleaning.</p> <p>B. Employee B did not remove her gloves or clean her hands in between removing Patient # 1's pants and cleansing the patient's wound site.</p> <p>C. Employee B did not clean her hands in between glove changes during wound care.</p> <p>D. Employee B did not have a clean and dirty side of the work bag. Employee was observed to remove and replace hand sanitizer inside the bag.</p> <p>4. On 12/30/13 at 3:00 p.m., Employee B was observed to have placed her work bag and clip board on Patient # 2's chair and floor without a barrier.</p> <p>A. Employee B was observed to remove the blood pressure cuff, thermometer, pulse oximeter, and stethoscope from the work bag, use it, and replace the items in the work bag without cleaning.</p> <p>B. Employee B did not have a clean</p>			

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	<p>and dirty side of her work bag. Employee was observed to remove and replace hand sanitizer inside the bag.</p> <p>3. A policy titled "Hand Hygiene" dated 7/23/12, indicated "[Name of Agency] employees will perform proper hand hygiene techniques to intervene in the potential for the transfer of disease causing organisms among all the patients to which the employees render care, their family members and the other staff providing care to the patients "</p> <p>4. The document titled "Cleaning and disinfection of Patient Care Equipment used in the Home Setting," March 2009 states, "One of the risks for transmitting infections to home care and hospice patients is the use of improperly cleaned and disinfected medical equipment. ... Non-critical Items- Non-critical items are those that come in contact with intact skin but not mucous membranes. ... Non-critical patient care items may include a blood pressure cuff, laptop computer keyboard, stethoscope, nursing bag taken into the home, pulse oximeter, etc. ... Non-critical environmental surfaces include the floor, bedside tables, side rails on a hospital bed in the home, television remote, light switches, and the patient's furniture. Many of these non-critical environmental</p>			

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	<p>surfaces are frequently touched by the staff member's hands and potentially could contribute to secondary transmission by contaminating the home care and hospice staff members' hands or by contacting medical equipment or non-critical patient care items that subsequently contact patients. This reinforces the need for staff to perform hand hygiene prior to having direct patient contact with the patient. ...</p> <p>Disinfection of Patient Care Equipment ... Most patient care equipment used by home care and hospice staff as well as surfaces touched by staff in the home would be considered non-critical. It is called non-critical as it carries little risk of causing an infection in patients or staff. However, patient care equipment (e.g., blood pressure cuffs, stethoscopes) can become contaminated with infectious agents (e.g., MRSA) and contribute to the transmission of infections. therefore, non-critical medical equipment surfaces should be disinfected with an EPA-registered low- or intermediate-level disinfectant at a minimum of when visibly soiled and on a regular basis (CDC, 2008). The term "regular basis" is to be defined by the home care and hospice organization. It is suggested that vital sign equipment and supplies be cleaned and disinfected with a low- or intermediate- level</p>			

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G000143	<p>disinfectant in the home after use and prior to placing the equipment back in the nursing bag for use on another patient." McGoldrick, M. (2009). Cleaning and Disinfection. Home Care Infection Prevention and Control Program. www.HomeCareandHopice.com <http://www.HomeCareandHopice.com>.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on clinical record and policy review review and interview, the agency failed to ensure the agency coordinated care with a discharging hospital prior to admission (# 2) for 1 of 2 admissions reviewed, all personnel furnishing services coordinated care effectively while services were being provided for 2 of 11 records reviewed (# 9 and 10) and the agency coordinated care upon a patient discharge to hospice services (# 10) for 1 of 2 records reviewed for discharges. This had the potential to affect all patients who received services with the agency.</p>	G000143	It is the intent of PHI to ensure the agency coordinates care.It is the intent of PHI to ensure all personnel furnishing patient services document the Coordination of Care while services are being provided.The therapists will be requested to either attend the weekly Case Conference meeting or submit a Case Conference form with an update on each patient on their service for coordination of care for review weekly. The Case Managers, Field Nurses, and Support Staff will document exchange of information from other staff members on a Communication Sheet reviewed at the weekly meeting to document coordination of	02/08/2014			

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	<p>Findings include:</p> <p>1. Clinical record # 2, SOC (start of care) 12/30/13, did not evidence coordination of care with a discharging hospital prior to the agency's initial evaluation and admission.</p> <p>Employee A, (Director of Nursing), was interviewed on 1/3/14 at 8:30 a.m. Employee A indicated the patient was initially supposed to have been admitted on 12/22/13, but discharge from the hospital had been put on hold. Employee A indicated the agency was not aware of the patient's discharge on 12/28/13 until staff returned to the office on Monday. Employee A indicated the agency was having difficulty obtaining paperwork from the discharging hospital. Employee A was requested to contact the hospital again for paperwork.</p> <p>2. Clinical record # 9, SOC (start of care) 9/26/13, evidenced the patient was receiving nursing, home health aide, and physical and occupational therapy services. The clinical record failed to evidenced coordination of services among the disciplines.</p> <p>3. Clinical record # 10, SOC 6/3/13, evidenced the patient was receiving</p>		<p>care. The PCC or designee will monitor for weekly therapy input and the use of Communication Sheets during the Case Conference Meetings. It is the intent of PHI to ensure our agency coordinates its services with other health or social services providers serving the patient. A policy and procedure entitled "Acquisition of Orders Prior to Admission" has been written. The Patient Care Coordinator (PCC) and Case Managers (CM) will share responsibility in obtaining all appropriate admission information. All CMs and Field Nurses will be in-serviced to reinforce appropriate admission information required and the necessity of coordination with a hospice upon patient discharge to the admitting hospice company. The Medical Records Clerk (MRC) will monitor the admission charts for the presence of the information outlined on the Admission Checklist. Any missing information will be reported to the PCC for immediate follow up. The MRC will report the monitoring results monthly at the QI Meeting. It is the intent of PHI to ensure the physician is notified of a patient's deteriorating condition. The Case Managers (CM) will complete a Communication Sheet documenting any significant change in a patient's condition and forward to the PCC. The PCC</p>		

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	<p>nursing, home health aide, and occupational therapy services. The clinical record failed to evidenced coordination of services among the disciplines.</p> <p>a. Clinical record # 10 failed to evidenced coordination with a hospice upon the patient discharge to the admitting hospice company.</p> <p>b. Employee B was interviewed on 12/31/13 at 4:00 p.m. Employee B indicated she did not contact the hospice company upon discharge.</p> <p>4. A policy titled "Client Plan of Care" dated 6/18/13, indicated the purpose was "To ensure continuity between disciplines in developing and implementing the Plan of Care ... When more than one service is involved, the Plan of Care will reflect cooperative care planning"</p> <p>5. A policy titled "Communication Sheet" dated 6/21/11, indicated "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator</p>		<p>or designee will review the patient's medical record for documentation of the physician contact. Non-compliance will be discussed with the CM for follow up.</p>		

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G000144	<p>(PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC"</p> <p>6. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated The Case Manager, under the guidance of physicians orders, will be the overall coordinator of home health services for the client. This includes consultation and collaboration between all professional staff who are seeing the same client, supervising other nursing staff, and making appropriate referrals as deemed necessary. All other professional staff are obliged to maintain liaison with the Case Manager ... "</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record and policy review and interview, the agency failed to ensure all personnel furnishing services documented the coordination of care while services was being provided</p>			G000144	It is the intent of PHI to ensure all personnel furnishing services document coordination of care. See G 143.		02/08/2014

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	<p>for 2 of 11 records reviewed. (# 9 and 10). This had the potential to affect all patients who received services with the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 9, SOC (start of care) 9/26/13, evidenced the patient was receiving nursing, home health aide, and physical and occupational therapy services. The clinical record failed to evidenced documentation of coordination of care among the staff. 2. Clinical record # 10, SOC 6/3/13, evidenced the patient was receiving nursing, home health aide, and occupational therapy services. The clinical record failed to evidenced documentation of coordination of care among the staff. <p>Employee B indicated during an interview on 12/31/13 at 4:00 p.m., that she should have documented coordination of care between nursing staff and therapy staff.</p> <ol style="list-style-type: none"> 3. A policy titled "Client Plan of Care" dated 6/18/13, indicated the purpose was "To ensure continuity between disciplines in developing and implementing the Plan of Care ... When 			

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	<p>more than one service is involved, the Plan of Care will reflect cooperative care planning ..."</p> <p>4. A policy titled "Communication Sheet" dated 6/21/11, indicated "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC ... "</p> <p>5. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated The Case Manager, under the guidance of physicians orders, will be the overall coordinator of home health services for the client. This includes consultation and collaboration between all professional staff who are seeing the same client, supervising other nursing staff, and making appropriate referrals as deemed necessary. All other professional staff are obliged to maintain liaison with the Case Manager. Communications between professional staff and Case manager regarding an individual client shall be documented in administrative note or on</p>						

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G000156	<p>communication form ... "</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on clinical record and policy review and interview, it was determined the agency failed to ensure treatments and visits were made as ordered for 3 of 11 clinical records reviewed (See G 158), failed to ensure Plan of Care included all medications and treatments for 1 of 11 records reviewed (See G 159), failed to ensure the physician was consulted to approve additions or modifications to the original plan of care after an initial evaluation visit for 2 of 11 clinical records reviewed (See G 160), failed to ensure orders for therapy services were received and included the specific procedures and modalities to be used and the frequency and duration of services in 1 of 4 clinical records reviewed of patients receiving therapy services (See G 161), failed to ensure the physical and occupational therapist participated in the development of the patient's written plan of care by obtaining specific therapy orders in 1 of</p>	G000156	It is the intent of PHI to ensure the agency processes for acceptance of patients, Plan of Care and Medical Supervision are within the guidelines of State and Federal Regulations. See G 158, G 159, G160, G 161, G 162, G, 164, G 165.	02/08/2014

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G000158	<p>4 clinical records reviewed of patients receiving therapy services (See G 162), failed to ensure the Physician was notified of a patient's deteriorating condition for 1 of 11 records reviewed (See G 164), and failed to ensure treatments and visits were made as ordered and only as ordered for 4 of 11 clinical records reviewed (See G 165) with the potential to affect all the agency's patients.</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the 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. Based on clinical record and policy review and interview, the agency failed to ensure treatments and visits were made as ordered and only as ordered for 4 of 11 clinical records reviewed. (# 1, 2, 9, and 10)</p>	G000158	<p>1.The following standards will be reviewed with the clinical staff a) The nurse will obtain orders from a physician for any changes in wound care treatment dressings.b) The nurse will notify any other shared provider of the physician's approval for any</p>	02/08/2014			

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	<p>Finding included:</p> <p>1. Clinical record # 1, SOC (start of care) 03/18/13, included a plan of care for the certification periods 07/16/13 to 09/13/13 and 09/14/13 to 11/12/13 with orders for wound care treatment of Prisma with Mepilex Border to the coccyx wound.</p> <p>a. Skilled nursing note dated 09/30/13 evidenced the Adhesive Restore was used on the coccyx wound.</p> <p>b. Skilled nursing note dated 10/24/13 evidenced "Repara" as the treatment used on the coccyx wound.</p> <p>c. Skilled nursing note dated 11/13/13 evidenced "Duoderm" as the treatment used on the coccyx wound.</p> <p>d. Employee A was interviewed on 12/31/13 at 3:00 p.m.. Employee A was not able to identify if the Prisma, Adhesive Restore, or Repara were equivalent treatment dressings. Employee A indicated the nurse should have obtained orders from the physician for changes in the wound care treatment dressings.</p> <p>2. During an initial / admission home</p>		<p>changes in frequency of visits.c) The RN will make supervisory visits as per regulations.d) The RN will update the Plan of Care and incorporate in the chart within 5 days of any change in services. e) The Case Manager will obtain start of care orders after the patient consents to home health services.2. Both Case Managers have been counseled and an Employee Conference Record placed in their personnel files. The Case Managers will monitor a patient care visit for each of the Field Nurses documenting the compliance of the visit with the patient's Plan of Care. The Case Managers will monitor each other during a patient care visit and document that care is being delivered per the Plan of Care. A summary of the visit observation will be documented on a Communication Sheet and will be shared with the Director of Nursing for any follow up needed.The Director of Nursing will review all charts for changes in services as identified by review of verbal orders and monitor for 5 day care plan update. The Medical Record Clerk will track supervisory visits and inform Director of Nursing when a problem is identified. The Director of Nursing or designee will audit all admission charts for documentation of physician orders prior to treatment. The Director of Nursing will be responsible for ensuring ongoing</p>		

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	<p>visit with Patient # 2 on 12/30/13 from 3:00 p.m. to 4:30 p.m., Employee B began a head to toe assessment and assisted the spouse on colostomy care. Employee B did not obtain start of care orders after the patient consented to home health services.</p> <p>Employee A, (Director of Nursing) was interviewed and indicated Employee B should have had orders from the physician after the patient consented to services.</p> <p>3. Clinical record # 9, SOC 09/26/13, evidenced [Name of Infusion Company] ordered Skilled Nursing visits daily for 5 days then weekly and prn (as needed) for assessment, safety, medications, education, disease management, wound care as physician ordered, intravenous therapy as physician ordered, PICC line care per agency protocol, and labs as physician ordered for the certification period 09/26/13 to 11/24/13. The patient was also to receive aide services 0 week 1, 2 times a week for 8 weeks, 0 week 1 beginning during week of 09/26/13. Clinical record # 9 failed to evidenced daily visits were made for the first 5 days of services.</p> <p>a. Employee A (Director of Nursing), on 1/3/14 at 11:45 a.m.,</p>		compliance with this regulation.				

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	<p>indicated the nursing staff should be following orders from [Name of Infusion Company]. Employee A indicated if there was a change in frequency of visits, the nurses would notify the [Name of Infusion Company] and physician for approval.</p> <p>b. The clinical record evidenced the first home health aide visit was made on 10/01/13. There was no evidence of a visit made week of 09/26/13.</p> <p>c. The employee record evidenced the patient was scheduled a second visit on 10/04/13. There was no supporting evidence to indicate the patient was seen on 10/04/13. Only one visit was made between 09/29/13 to 10/05/13.</p> <p>4. Clinical Record # 10, SOC 06/03/13, with physician plan of care orders 10/01/13 to 11/29/13 for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare and home health aid 1 time a week for 1 week, then 2 times a week for 8 weeks starting the week of 10/01/13.</p> <p>a. The clinical record did not evidenced that a supervisory visit of the home health aide was completed between 10/17/13 to 11/04/13 and again</p>						

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	<p>between 11/04/13 to 11/20/13.</p> <p>5. A policy titled "Client Plan of Care" dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client ... "</p> <p>6. A policy titled "Medical policies and physician's orders" dated 09/28/07, indicated "At times, the physician's orders may be changed, discontinued, or added in between 60-day renewals. If this occurs, the change of orders shall be sent to the physician for signature of approval of the change/new orders. The Field Nurse shall be responsible to see the change of orders is sent to the physician ... "</p> <p>7. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated "The Case Manager, under the guidance of physicians orders, will be the overall coordinator of home health services for the client ... supervising other nursing staff ... "</p>				

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G000159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, the agency failed to ensure Plan of Care included all medications and treatments for 1 of 11 records reviewed. (# 9)</p> <p>Findings include:</p> <p>Clinical record # 9, start of care 09/26/13, included a plan of care for the certification period 09/26/13 to 11/24/13 that failed to evidenced acetaminophen-hydrocodone (pain medication) 5-325 mg (milligrams) by mouth four times a day as needed, allopurinol (prevent uric acid build up / gout medication) 300 mg by mouth daily, aspirin 81 mg by mouth daily, captopril (antihypertensive) 12.5 mg by mouth daily, citalopram (antidepressant) 20 mg by mouth daily, divalproex sodium (mood stabilizer) 125 mg by</p>	G000159	<p>1. The Case Managers will include medications and treatments on the Plan of Care.2. The Case Managers will be in-serviced on documenting medications and treatments on the Start Of Care Plan of Care and updating these as needed at re-certification time. 3. The Director of Nursing will monitor the Plan of Care for the presence of medications and treatments and follow up with the Case Managers for any non-compliance. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.</p>	02/08/2014

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	<p>mouth daily, docusate (stool softner) 100 mg by mouth daily as needed, esomeprazole (stomach reflux prevention) 20 mg by mouth daily, furosemide (diuretic) 20 mg by mouth daily, gas-x (bloating) extra strength 125 mg by mouth daily as needed, lorazepam (antianxiety) 0.5 mg by mouth twice a day as needed, namenda (dementia/Alzheimer) 10 mg by mouth twice a day, polyethylene glycol (stool softners) 3350 17 gm (grams) by mouth daily as needed, pradaxa (blood thinner) 150 mg by mouth twice a day, ProAir HFA 1 puff inhaler (lung disease) four times a day as needed, trazodone (sleep) 100 mg by mouth daily at bedtime, and tylenol 650 mg by mouth every four hours as needed. The plan of care failed to evidence flow rate of Intravenous Total Parental Nutrition, treatment instructions for fistula care, and specific labs ordered for monitoring of the TPN such as complete blood count with differential, complete metabolic panel, magnesium, phosphorus, and prealbumin every Monday, basic metabolic profile and prealbumin on Thursdays, and Triglycerides and lipids monthly. The plan of care failed to evidenced the responsible medical staff to be notified of the lab results.</p>						

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G000160	<p>484.18(a) PLAN OF CARE</p> <p>If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan.</p> <p>Based on clinical record review and interview, the agency failed to ensure the physician was consulted to approve additions or modifications to the original plan of care after an initial evaluation visit for 2 of 11 clinical records reviewed. (# 7 and 9)</p> <p>Finding included:</p> <p>1. Clinical record # 9, start of care 9/26/13, evidenced [Name of Infusion Company] ordered Skilled Nursing visits daily for 5 days then weekly and prn (as needed) for assessment, safety, medications, education, disease management, wound care as physician ordered, intravenous therapy as physician ordered, PICC line care per agency protocol and labs as physician ordered. The record failed to evidence the physician approved the infusion company orders.</p> <p>Interview with Employee A (Director of Nursing) on 1/3/14 at 11:45 a.m., indicated the nursing staff should</p>	G000160	<p>It is the intent of PHI to ensure the physician is consulted to approve additions or modifications to the original Plan of Care after an initial evaluation visit. See G 158 The Case Managers, Physical Therapists and Occupational Therapists will contact the physician regarding treatment and Plan of Care orders prior to rendering services. The physician contact will be noted in the clinicians visit notes. Each admission chart will be monitored by the PCC or designee for three months and results reported to the Quality Control Committee monthly.</p>	02/08/2014
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	<p>be following orders from [Name of Infusion Company]. Employee A indicated if there was a change in frequency of visits, the nurses would notify the [Name of Infusion Company] and physician for approval.</p> <p>2. Clinical record # 7, start of care 12/12/13, included a plan of care established by the physician for the certification period 12/12/13 through 2/9/14 with orders for a physical therapy (P.T.) and occupational therapy (O.T.) evaluation and treatment. The P.T. and O.T. evaluations were each completed on 12/13/13 (day 1 of the certification period). Physical therapy treatments were provided on December 17, 19, 23, and 27, 2013. Occupational treatments were provided on December 17, 8, 23, and 30, 2013. The plan of care and clinical record failed to evidence any physician orders for the PT and OT treatments.</p> <p>On 1/2/14 at 2 PM, employee A indicated their was no documentation to evidence a physician was consulted regarding the therapy treatments to be provided prior to rendering of those therapy services.</p> <p>3. On 1/2/14 at 2:04 PM, employee I, an occupational therapist, indicated she</p>						

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G000161	<p>does not call the physician for specific treatment orders following the assessment. She indicated she writes her treatment plan and it is submitted to the physician by someone other than herself.</p> <p>484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. Based on clinical record and agency policy review and interview, the agency failed to ensure orders for therapy services were received and included the specific procedures and modalities to be used and the frequency and duration of services in 1 (# 8) of 4 clinical records reviewed of patients receiving therapy services and the potential to affect all therapy patients.</p> <p>The findings include:</p> <p>1. Clinical record # 7, start of care 12/12/13 included a plan of care established by the physician for the certification period 12/12/13 through 2/9/14 with orders for a physical therapy (P.T.) and occupational therapy (O.T.) evaluation and treatment. The P.T. and O.T. evaluations were each completed on 12/13/13 (day 1 of the certification</p>	G000161	The Physical Therapist and Occupational Therapist will be in-serviced on the regulation requiring physician orders be received prior to treatment for specific procedures, modalities, frequency and duration of services. The Quality Improvement RN will audit all physical therapist and occupational therapist initial evaluations for documentation of physician contact for treatment orders. The therapist will be contacted for corrections. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014			

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	<p>period). Physical therapy treatments were provided on December 17, 19, 23, and 27, 2013. Occupational treatments were provided on December 17, 18, 23, and 30, 2013. The plan of care and clinical record failed to evidence the physical therapist and the occupational therapist participated in the plan of care and obtained any written or verbal physician orders for the treatments. The record evidenced the OT wrote a treatment order on 12/18/13 which was submitted to the physician on 12/30/13. The record evidenced the PT wrote a PT treatment order on 12/18/13 which was submitted to the physician on 12/19/13.</p> <p>On 1/2/14 at 2 PM, employee A, a registered nurse, indicated their was no documentation to evidence a physician was consulted regarding the therapy treatments to be provided prior to rendering of those therapy services.</p> <p>2. On 1/2/14 at 2:04 PM, employee I, an occupational therapist, indicated she does not call the physician for specific treatment orders following the assessment. She indicated she writes her treatment plan and it is submitted to the physician by someone other than herself.</p> <p>3. A policy titled "Client Plan of Care"</p>						

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G000162	<p>dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client."</p> <p>484.18(a) PLAN OF CARE The therapist and other agency personnel participate in developing the plan of care. Based on clinical record and policy review and interview, the agency failed to ensure the physical and occupational therapist participated in the development of the patient's written plan of care by obtaining specific orders for therapy treatments in 1 (# 8) of 4 clinical records reviewed of patients receiving therapy services and the potential to affect all therapy patients.</p> <p>The findings include:</p> <p>1. Clinical record # 7, start of care 12/12/13 included a plan of care established by the physician for the certification period 12/12/13 through 2/9/14 with orders for a physical therapy (P.T.) and occupational therapy (O.T.) evaluation and treatment. The P.T. and O.T. evaluations were each completed</p>	G000162	The Physical Therapist and Occupational Therapist will be in-serviced on the regulations requiring participation in the developing of the Plan of Care by obtaining specific orders for therapy treatments prior to treating patients. The Quality Improvement RN will audit all physical therapy and occupational therapy initial evaluations for documentation of physician contact for treatment orders and incorporation into the Plan of Care. The therapist will be contacted for corrections. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014			

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	<p>on 12/13/13 (day 1 of the certification period). Physical therapy treatments were provided on December 17, 19, 23, and 27, 2013. Occupational treatments were provided on December 17, 18, 23, and 30, 2013. The plan of care and clinical record failed to evidence the physical therapist and the occupational therapist participated in the plan of care and obtained any written or verbal physician orders for the treatments.</p> <p>On 1/2/14 at 2 PM, employee A, a registered nurse, indicated their was no documentation to evidence a physician was consulted regarding the therapy treatments to be provided prior to rendering of those therapy services.</p> <p>2. On 1/2/14 at 2:04 PM, employee I, an occupational therapist, indicated she does not call the physician for specific treatment orders following the assessment. She indicated she writes her treatment plan and it is submitted to the physician by someone other than herself.</p> <p>3. A policy titled "Client Plan of Care" dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five</p>						

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G000164	<p>days of any change in services to be provided to the client."</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record review, the agency failed to ensure the Physician was notified of a patient's deteriorating condition for 1 of 11 records reviewed (# 10) with the potential to affect all the agency patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical Record # 10, start of care 06/03/13, included a plan of care for the certification period 10/01/13 to 11/29/13 with orders for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare. 2. A skilled nursing visit note dated 10/03/13, evidenced the patient was not eating much due to fatigue and chewing and swallowing was not easy. The spouse was encouraged to offer softer foods. The note evidenced the patient had lost 5 more pounds. The note stated, "No one contacted as a result of this visit ... " 	G000164	The Case Managers, Field Nurses, and therapists will be in-serviced on the need to alert the physician to any changes in a patient's condition. The therapists will contact the Case Managers for any physician contact made or needed. The Case Managers and Field Nurses will complete a Communication Sheet that a physicians contact was made for a change in condition. The Quality Improvement RN or designee will monitor these Communication Sheets to audit for medical record documentation. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014			

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	<p>3. A skilled nursing visit note dated 11/4/13, evidenced the patient diet consisted of high protein, calorie dense diet. The patient had lost significant weight. The patient was started on Remeron 7.5 mg (milligram) at bedtime to stimulate appetite. The note evidenced the patient had significant weight loss. The patient was unable to stand on the scale, but the dentures, eye glasses, and clothing were now too large. The note evidenced "no one contacted as a result of this visit ... "</p> <p>4. A Communication Sheet dated 11/21/13, evidenced a phone conversation between the patient's spouse and the case manager. The note indicated the spouse canceled the home health aide visit and indicated "[name of patient] is really going downhill quickly, much worse since Sunday." The spouse and family were considering hospice.</p>			

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G000165	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record and policy review and interview, the agency failed to ensure treatments and visits were made as ordered and only as ordered for 4 of 11 clinical records reviewed (# 1, 2, 9, and 10) with the potential to affect all the agency's patients.</p> <p>Finding included:</p> <p>1. Clinical record # 1, SOC (start of care) 03/18/13, included a plan of care for the certification periods 07/16/13 to 09/13/13 and 09/14/13 to 11/12/13 with orders for wound care treatment of Prisma with Mepilex Border to the coccyx wound.</p> <p>a. Skilled nursing note dated 09/30/13 evidenced the Adhesive Restore was used on the coccyx wound.</p> <p>b. Skilled nursing note dated 10/24/13 evidenced "Repara" as the treatment used on the coccyx wound.</p> <p>c. Skilled nursing note dated 11/13/13 evidenced "Duoderm" as the</p>	G000165	<p>1.The following standards will be reviewed with the clinical staff a) The nurse will obtain orders from a physician for any changes in wound care treatment dressings.b) The nurse will notify any other shared provider of the physician's approval for any changes in frequency of visits.c) The RN will make supervisory visits as per regulations.d) The RN will update the Plan of Care and incorporate in the chart within 5 days of any change in services. e) The Case Manager will obtain start of care orders after the patient consents to home health services.2. Both Case Managers have been counseled and an Employee Conference Record placed in their personnel files. The Director of Nursing or designee will review all charts for changes in services or treatments as identified by review of verbal orders and monitor for 5 day care plan update. The Medical Record Clerk will track supervisory visits and inform the Director of Nursing when a problem is identified. The Director of Nursing or designee will audit all admission charts for documentation of physician orders prior to treatment.The</p>	02/08/2014			

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	<p>treatment used on the coccyx wound.</p> <p>d. Employee A was interviewed on 12/31/13 at 3:00 p.m.. Employee A was not able to identify if the Prisma, Adhesive Restore, or Repara were equivalent treatment dressings. Employee A indicated the nurse should have obtained orders from the physician for changes in the wound care treatment dressings.</p> <p>2. During an initial / admission home visit with Patient # 2 on 12/30/13 from 3:00 p.m. to 4:30 p.m., Employee B began a head to toe assessment and assisted the spouse on colostomy care. Employee B did not obtain start of care orders after the patient consented to home health services.</p> <p>Employee A, (Director of Nursing) was interviewed and indicated Employee B should have had orders from the physician after the patient consented to services.</p> <p>3. Clinical record # 9, SOC 09/26/13, evidenced [Name of Infusion Company] ordered Skilled Nursing visits daily for 5 days then weekly and prn (as needed) for assessment, safety, medications, education, disease management, wound care as physician ordered, intravenous</p>		Quality Improvement RN will be monitoring the certification time points for complete and accurate documentation. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.		

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	<p>therapy as physician ordered, PICC line care per agency protocol, and labs as physician ordered for the certification period 09/26/13 to 11/24/13. The patient was also to receive aide services 0 week 1, 2 times a week for 8 weeks, 0 week 1 beginning during week of 09/26/13. Clinical record # 9 failed to evidenced daily visits were made for the first 5 days of services.</p> <p>Employee A (Director of Nursing), on 1/3/14 at 11:45 a.m., indicated the nursing staff should be following orders from [Name of Infusion Company]. Employee A indicated if there was a change in frequency of visits, the nurses would notify the [Name of Infusion Company] and physician for approval.</p> <p>4. Clinical Record # 10, SOC 06/03/13, with physician plan of care orders 10/01/13 to 11/29/13 for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare and home health aid 1 time a week for 1 week, then 2 times a week for 8 weeks starting the week of 10/01/13.</p> <p>a. The clinical record did not evidenced that a supervisory visit of the home health aide was completed between 10/17/13 to 11/04/13 and again</p>						

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G000168	<p>between 11/04/13 to 11/20/13.</p> <p>5. A policy titled "Client Plan of Care" dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client ... "</p> <p>6. A policy titled "Medical policies and physician's orders" dated 09/28/07, indicated "At times, the physician's orders may be changed, discontinued, or added in between 60-day renewals. If this occurs, the change of orders shall be sent to the physician for signature of approval of the change/new orders. The Field Nurse shall be responsible to see the change of orders is sent to the physician ... "</p> <p>7. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated "The Case Manager, under the guidance of physicians orders, will be the overall coordinator of home health services for the client ... supervising other nursing staff ... "</p> <p>484.30 SKILLED NURSING SERVICES</p>						

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	<p>Based on clinical record review, policy review and interview, it was determined the agency failed to ensure skilled nursing services were provided as ordered and only as ordered for 4 of 11 clinical records reviewed (See G 170), failed to ensure the registered nurse included the patients weight in the assessment and completed a total assessment of the patient's wounds for 2 of 10 clinical records reviewed that received skilled nursing services (See G 172), failed to ensure the plan of care was revised when orders were unclear and when the patient's condition deteriorated for 2 of 11 clinical records reviewed (See G 173), failed to ensure the agency coordinated care with a discharging hospital prior to admission for 1 of 2 admissions reviewed, all personnel furnishing services coordinated care effectively while services were being provided for 2 of 11 records reviewed and the agency coordinated care upon a patient discharge to hospice services for 1 of 2 records reviewed for discharges (See G176), and ensure the registered nurse counsels the patient and family in meeting nursing and related needs in 1 of 11 clinical records reviewed (See G 177).</p> <p>The cumulative effect of these systemic</p>	G000168	It is the intent of PHI to provide skilled nursing services in accordance with Federal and State Regulations. See G170, G172, G173, G176, and G177.	02/08/2014	

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G000170	<p>problems resulted in the Condition of Participation 484.30: Skilled Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and policy review and interview, the agency failed to ensure skilled nursing services were provided as ordered and only as ordered for 4 of 11 clinical records reviewed (# 1, 2, 9, and 10) with the potential to affect all patients receiving skilled nursing services.</p> <p>Finding included:</p> <p>1. Clinical record # 1, SOC (start of care) 03/18/13, included a plan of care for the certification periods 07/16/13 to 09/13/13 and 09/14/13 to 11/12/13 with orders for wound care treatment of Prisma with Mepilex Border to the coccyx wound.</p> <p>a. Skilled nursing note dated 09/30/13 evidenced the Adhesive</p>	G000170	<p>1.The following standards will be reviewed with the clinical staff. a) The nurse will obtain orders from a physician for any changes in wound care treatment dressings.b) The nurse will notify any other shared provider of the physician's approval for any changes in frequency of visits.c) The RN will make supervisory visits as per regulations.d) The RN will update the Plan of Care and incorporate in the chart within 5 days of any change in services. e) The Case Manager will obtain start of care orders after the patient consents to home health services.2. Both Case Managers have been counseled and an Employee Conference Record placed in their personnel files. The Case Managers will monitor a patient care visit for each of the Field Nurses documenting the compliance of the visit with the patient's Plan of Care.The Case</p>	02/08/2014

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	<p>Restore was used on the coccyx wound.</p> <p>b. Skilled nursing note dated 10/24/13 evidenced "Repara" as the treatment used on the coccyx wound.</p> <p>c. Skilled nursing note dated 11/13/13 evidenced "Duoderm" as the treatment used on the coccyx wound.</p> <p>d. Employee A was interviewed on 12/31/13 at 3:00 p.m.. Employee A was not able to identify if the Prisma, Adhesive Restore, or Repara were equivalent treatment dressings. Employee A indicated the nurse should have obtained orders from the physician for changes in the wound care treatment dressings.</p> <p>2. During an initial / admission home visit with Patient # 2 on 12/30/13 from 3:00 p.m. to 4:30 p.m., Employee B began a head to toe assessment and assisted the spouse on colostomy care. Employee B did not obtain start of care orders after the patient consented to home health services.</p> <p>Employee A, (Director of Nursing) was interviewed and indicated Employee B should have had orders from the physician after the patient consented to services.</p>		<p>Managers will monitor each other during a patient care visit and document that care is being delivered per the Plan of Care. The Director of Nursing will review all charts for changes in services as identified by review of verbal orders and monitor for 5 day care plan update. The Medical Record Clerk will track supervisory visits and inform Director of Nursing when a problem is identified. The Director of Nursing or designee will audit all admission charts for documentation of physician orders prior to treatment. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.</p>		

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	<p>3. Clinical record # 9, SOC 09/26/13, evidenced [Name of Infusion Company] ordered Skilled Nursing visits daily for 5 days then weekly and prn (as needed) for assessment, safety, medications, education, disease management, wound care as physician ordered, intravenous therapy as physician ordered, PICC line care per agency protocol, and labs as physician ordered for the certification period 09/26/13 to 11/24/13. The patient was also to receive aide services 0 week 1, 2 times a week for 8 weeks, 0 week 1 beginning during week of 09/26/13. Clinical record # 9 failed to evidenced daily visits were made for the first 5 days of services.</p> <p>Employee A (Director of Nursing), on 1/3/14 at 11:45 a.m., indicated the nursing staff should be following orders from [Name of Infusion Company]. Employee A indicated if there was a change in frequency of visits, the nurses would notify the [Name of Infusion Company] and physician for approval.</p> <p>4. Clinical Record # 10, SOC 06/03/13, with physician plan of care orders 10/01/13 to 11/29/13 for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare and home health aid</p>				

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	<p>1 time a week for 1 week, then 2 times a week for 8 weeks starting the week of 10/01/13.</p> <p>a. The clinical record did not evidenced that a supervisory visit of the home health aide was completed between 10/17/13 to 11/04/13 and again between 11/04/13 to 11/20/13.</p> <p>5. A policy titled "Client Plan of Care" dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client ... "</p> <p>6. A policy titled "Medical policies and physician's orders" dated 09/28/07, indicated "At times, the physician's orders may be changed, discontinued, or added in between 60-day renewals. If this occurs, the change of orders shall be sent to the physician for signature of approval of the change/new orders. The Field Nurse shall be responsible to see the change of orders is sent to the physician ... "</p> <p>7. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated "The Case Manager, under the</p>						

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G000172	<p>guidance of physicians orders, will be the overall coordinator of home health services for the client ... supervising other nursing staff ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>2. Clinical record # 3, start of care 11/14/13, diagnosis chronic renal failure and Diabetes mellitus, included a plan of care for the certification period 11/14/13 through 1/13/14 that contained orders for skilled nursing once a week for eight weeks and a home health aide twice a week. The record evidenced the aide reported blisters on the patient's feet on 12/5/13.</p> <p>A. The skilled nurse visit note dated 12/6/13 evidenced documentation of a skin assessment which included on the right foot: 1) A fluid filled blister on the top of the foot that measured 0.5 centimeters (cm) length and 3.4 cm width, 2) A blister on the lateral outer aspect that was fluid filled and measured 4.6 cm length and 3.7 cm width, 3) A black eschar blister to the lateral side of the small toe that measured 0.6 cm length and 0.4 cm</p>	G000172	The Case Managers and Field Nurses will be in-serviced on their responsibility to re-evaluate the patient's nursing needs with emphasis on conducting thorough skin assessments and weight monitoring. The Director of Nursing or designee will monitor all verbal orders and Plans of Care for documentation of patient skin or weight issues and audit the medical record for appropriate documentation. Any non-compliance will be addressed with the Case Managers and/or Field Nurses. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014

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	<p>width, 4) A blood blister on the bottom of the small toe that measured 1.2 cm length and 1.0 cm width, 5) A blood blister on the under side of the second toe that measured 1.0 cm length and 1.5 cm width; and 6) A crescent shaped open area on the top of the second toe measured 0.5 cm length and 0.2 cm width. Blisters on the left foot included one that measured 0.2 cm length and 0.4 cm width located on the tip of the fifth toe and an open blister on the top of the fourth toe that measured 0.5 cm length and 1.1 cm width. The nurse note evidenced both feet with pitting edema of +3. The attending physician was contacted and the patient was admitted to the hospital and treated for cellulitis.</p> <p>B. The patient was discharged to home on on 12/8/13. The record evidenced employee B completed a resumption of care comprehensive assessment on 12/9/13 that failed to include a skin assessment that included the status and condition of the patient's skin and the condition of all the previous blisters on the patients feet.</p> <p>C. The record evidenced a skilled nurse visit was completed by</p>				

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	<p>employee L on 12/10/13 and included the purpose of the visit was to assess wounds of the feet. The visit documentation evidenced a blister was intact on the right foot, outer aspect and that the nurse was awaiting physician orders for treatment and a dry dressing was applied until further orders were received. No reference to any other skin issue was documented within the visit note.</p> <p>D. The record evidenced the next patient visit was on 12/17/13 and completed by employee L. The documentation indicated the blister on the right lateral foot had ruptured. No reference to any other skin issue was documented within the visit note.</p> <p>E. The record evidenced the next skilled nurse visit was on 12/24/13 and completed by employee L. The documentation indicated the area where the blister on the right lateral foot had ruptured was intact and free of signs and symptoms of infection. No other reference to the patient's skin was noted on the visit note.</p> <p>F. During a home visit on 12/31/13 at 11 AM, the patient was</p>				

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	<p>observed with dry scarred areas on the top of the foot and one on the outer aspect of the right foot. Also three dark dry areas on the fifth toe and three dark dry areas on the second toe. Employee B indicated, when asked, the dark areas were long standing chronic areas, and stated they were "there from the beginning" and that the [caregiver name] was providing care daily and that the nurse was not tracking these areas. The caregiver indicated the dark dry areas on the patient's feet were chronic and informed the nurse that he / she had not monitored since Thanksgiving as was not physically capable.</p> <p>H. On 1/8/14 at 11:15 AM, employee B indicated all of the patient's skin lesions and wounds should be documented and monitored.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse included the patients weight in the assessment and completed</p>			

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	<p>a total assessment of the patient's wounds for 2 of 10 clinical records reviewed of patients that received skilled nursing services (# 3 and 10). This had the potential to affect all patients who received skilled nursing services with the agency.</p> <p>Findings include:</p> <p>1. Clinical Record # 10, start of care 06/03/13, included a plan of care for the certification period with orders for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare.</p> <p>a. A soc comprehensive assessment dated 06/03/13, indicated the patient had excessive weight loss, poor appetite and a 10 pound weight loss in the previous six months without trying. No weight was obtained or ordered at the time of admission.</p> <p>b. A recertification comprehensive assessment dated 08/01/13, indicated the patient had excessive weight loss, poor appetite and a 10 pound weight loss in the previous six months. No weight was obtained or ordered at the time of recertification.</p>						

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	<p>c. A skilled nursing visit note dated 09/09/13, indicated the patient only tolerated small amounts of food. The spouse was educated on the patient's need for protein and exercise. The case manager was notified of the changes. No weight was obtained as a nursing measure.</p> <p>d. A skilled nursing visit note dated 10/03/13, evidenced the patient was not eating much due to fatigue and chewing and swallowing was not easy. The spouse was encouraged to offer softer foods. The note evidenced the Patient had lost 5 more pounds. No weight was obtained as a nursing measure.</p> <p>e. A skilled nursing visit note dated 11/04/13, evidenced the patient diet consist of high protein, calorie dense diet. The patient had lost significant weight. The patient was started on Remeron 7.5 mg (milligram) at bedtime to stimulate appetite. The note evidenced the patient had significant weight loss, unable to stand on the scale, dentures, eye glasses and clothing were too large.</p> <p>f. Employee B was interviewed on 12/31/13 at 4:00 p.m. Employee B indicated she did not obtain a weight for the patient.</p>				

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G000173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care was revised when orders were unclear and when the patient's condition deteriorated for 2 of 11 clinical records reviewed. This had the potential to affect all patients who were receiving care from the agency. (# 1 and 10)</p> <p>Findings include:</p> <p>1. Clinical record # 1, SOC (start of care) 03/18/13, included a plan of care for the certification periods 07/16/13 to 09/13/13 and 09/14/13 to 11/12/13 with orders for wound care of Prisma with Mepilex Border to the coccyx wound.</p> <p>a. Skilled nursing notes dated 10/03/13, 10/15/13, and 10/17/13 evidenced "Adhesive Restore" as the treatment used on the coccyx wound.</p> <p>b. Skilled nursing note dated 10/24/13 evidenced "Repara" as the treatment used on the coccyx wound.</p> <p>c. Skilled nursing note dated 11/13/13 evidenced "Duoderm" as the</p>	G000173	The Case Managers and Field Nurses will be in-serviced on the need to revise the Plan of Care when orders are unclear and when a patient's condition deteriorates. The Director of Nursing or designee will monitor all verbal orders and Plans of Care for clarification of orders and care plan alterations. Any non-compliance will be addressed with the Case Managers and/or Field Nurses. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014			

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	<p>treatment used on the coccyx wound.</p> <p>d. Employee A was interviewed on 12/31/13 at 3:00 p.m.. Employee A was not able to identify if the Prisma, Adhesive Restore, or Repara was equivalent treatment dressings. Employee A indicated the nurse should have obtained orders from the physician for changes in the wound care treatment dressings.</p> <p>2. Clinical Record # 10, SOC 06/03/13, included a plan of care for the certification period 10/1/13 to 11/29/13 with orders for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare.</p> <p>a. A skilled nursing visit note dated 10/03/13 evidenced the patient was not eating much due to fatigue and chewing and swallowing was not easy. The spouse was encouraged to offer softer foods. The note evidenced the Patient had lost 5 more pounds and the neurologist suggested a feeding tube for the patient. The note evidenced "no one contacted as a result of this visit ... " Documentation failed to evidence the nurse considered revisions to the care plan.</p>						

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	<p>b. A skilled nursing visit note dated 11/04/13 evidenced the patient diet consist of high protein, calorie dense diet. The patient had lost significant weight. The patient was started on Remeron 7.5 mg (milligram) at bedtime to stimulate appetite. The note evidenced the patient had significant weight loss. The patient was unable to stand on the scale, but the dentures, eye glasses and clothing were now too large. The note evidenced "no one contacted as a result of this visit ... " Documentation failed to evidence the nurse considered revisions to the care plan.</p> <p>3. A policy titled "Client Plan of Care" dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client ... "</p> <p>4. A policy titled "Medical policies and physician's orders" dated 09/28/07, indicated "At times, the physician's orders may be changed, discontinued, or added in between 60-day renewals. If this occurs, the change of orders shall be sent to the physician for signature of approval of the change/new orders. The Field Nurse shall be responsible to see</p>						

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G000176	<p>the change of orders is sent to the physician ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record and policy review review and interview, the agency failed to ensure the agency coordinated care with a discharging hospital prior to admission (# 2) for 1 of 2 admissions reviewed, all personnel furnishing services coordinated care effectively while services were being provided for 2 of 11 records reviewed (# 9 and 10) and the agency coordinated care upon a patient discharge to hospice services (# 10) for 1 of 2 records reviewed for discharges. This had the potential to affect all patients who received services with the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 2, SOC (start of care) 12/30/13, did not evidence coordination of care with a discharging hospital prior to the agency's initial evaluation and admission.</p>	G000176	It is the intent of PHI to ensure all personnel furnishing patient services document the Coordination of Care while services are being provided. The therapists will be requested to either attend the weekly Case Conference meeting or submit a Case Conference form with an update on each patient on their service for coordination of care for review weekly. The Case Managers, Field Nurses, and Support Staff will document exchange of information from other staff members on a Communication Sheet reviewed at the weekly meeting to document coordination of care. The PCC or designee will monitor for weekly therapy input and the use of Communication Sheets during the Case Conference Meetings. It is the intent of PHI to ensure our agency coordinates its services with other health or social services providers serving the patient. A policy and procedure	02/08/2014			

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	<p>Employee A, (Director of Nursing), was interviewed on 1/3/14 at 8:30 a.m. Employee A indicated the patient was initially supposed to have been admitted on 12/22/13, but discharge from the hospital had been put on hold. Employee A indicated the agency was not aware of the patient's discharge on 12/28/13 until staff returned to the office on Monday. Employee A indicated the agency was having difficulty obtaining paperwork from the discharging hospital. Employee A was requested to contact the hospital again for paperwork.</p> <p>2. Clinical record # 9, SOC (start of care) 9/26/13, evidenced the patient was receiving nursing, home health aide, and physical and occupational therapy services. The clinical record failed to evidenced coordination of services among the disciplines.</p> <p>3. Clinical record # 10, SOC 6/3/13, evidenced the patient was receiving nursing, home health aide, and occupational therapy services. The clinical record failed to evidenced coordination of services among the disciplines.</p> <p>a. Clinical record # 10 failed to evidenced coordination with a hospice</p>		<p>entitled "Acquisition of Orders Prior to Admission" has been written. The Patient Care Coordinator (PCC) and Case Managers (CM) will share responsibility in obtaining all appropriate admission information. All CMs will be in-serviced to reinforce appropriate admission information required and the necessity of coordination with a hospice upon patient discharge to the admitting hospice company. The Medical Records Clerk (MRC) will monitor the admission charts for the presence of the information outlined on the Admission Checklist. Any missing information will be reported to the PCC for immediate follow up. The MRC will report the monitoring results monthly at the QI Meeting.</p>		

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	<p>upon the patient discharge to the admitting hospice company.</p> <p>b. Employee B was interviewed on 12/31/13 at 4:00 p.m. Employee B indicated she did not contact the hospice company upon discharge.</p> <p>4. A policy titled "Client Plan of Care" dated 6/18/13, indicated the purpose was "To ensure continuity between disciplines in developing and implementing the Plan of Care ... When more than one service is involved, the Plan of Care will reflect cooperative care planning"</p> <p>5. A policy titled "Communication Sheet" dated 6/21/11, indicated "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC"</p> <p>6. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated The Case Manager, under the guidance of physicians orders, will be the overall</p>						

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G000186	<p>coordinator of home health services for the client. This includes consultation and collaboration between all professional staff who are seeing the same client, supervising other nursing staff, and making appropriate referrals as deemed necessary. All other professional staff are obliged to maintain liaison with the Case Manager ... "</p> <p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) Based on clinical record review, policy review, and interview, the agency failed to ensure the Occupational Therapy reassessed a patient upon return from the hospital for 1 of 4 records reviewed that received occupational therapy. This had the potential to affect all patients who were receiving Occupational Therapy services. (# 9)</p> <p>Finding include: 1. Clinical record # 9, SOC (start of care) 09/26/13, included a plan of care for the certification period 09/26/13 to</p>	G000186	The Physical Therapist and Occupational Therapist will be in-serviced concerning assisting the physicians in evaluating the patient's level of function and helping develop the Plan of Care. The "Therapy Policies and Procedures" will be revised to include resumption of care evaluations by Physical Therapist and Occupational Therapist and reviewed with both therapies. The Case Manager will be responsible for contacting the Physical Therapist and Occupational Therapist when a patient's care is resumed in order to schedule a ROC therapy evaluation. The therapist will contact the Case	02/08/2014			

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G000188	<p>11/24/13 that evidenced Occupational Therapy was started on 10/01/13 and discontinued on 10/17/13.</p> <p>a. The clinical record evidenced the patient was admitted into the hospital on 10/08/13 and returned on 10/10/13. The clinical record did not evidenced the occupational therapist made a reassessment after resumption of care from a hospitalization. The clinical record evidenced the occupational therapist made a routine visit.</p> <p>b. Employee A (Director of Nursing) was interviewed and had indicated the occupational therapist should have re-evaluation the patient upon return from the hospital.</p> <p>2. A policy titled "Therapy Policies" dated 10/06, indicated "The reassessment shall reflect the client's reaction to treatment and changes in the client's condition ... "</p> <p>484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel. Based on clinical record review, policy</p>			G000188	<p>Manager when the ROC is scheduled and when completed. The Case Managers will inform the Director of Nursing of non-compliance. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.</p> <p>The Physical Therapist and Occupational Therapist will be</p>		02/08/2014

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	<p>review, and interview, the agency failed to ensure qualified therapists advised and consulted with agency personnel for 2 of 4 clinical records reviewed that received therapy services (#9 and 10). This had the potential to affect all patient who were receiving therapy services.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Clinical record # 9, SOC (start of care) 09/26/13, evidenced the patient was receiving skilled nursing, home health aide, and physical and occupational therapy services. The clinical record failed to evidence communication between the disciplines. 2. Clinical record # 10, SOC 06/03/13, evidenced the patient was receiving skilled nursing, home health aide, and occupational therapy services. Occupational therapy missed visit notes dated 10/19/13 and 10/20/13 did not evidenced communication between the occupational therapist and the case manager. The missed visit notes evidenced the patient did not feel well. 3. A policy titled "Therapy Policies" dated 10/06, indicated "The therapist shall consult and collaborate with the professional nurse who is case manager 		<p>in-serviced on the necessity of advising and consulting with agency personnel. The Physical Therapist and Occupational Therapist will provide weekly written updates for Case Managers review. Any therapy contacts with the Case Managers will be documented on a Communication Sheet and forwarded to the Director of Nursing or designee for review. The Case Managers will contact the therapists for any non-compliance. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.</p>		

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	<p>of the physician's Plan of Care.</p> <p>4. A policy titled "Communication Sheet" dated 06/21/11, indicated "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC ... "</p> <p>5. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated The Case Manager, under the guidance of physicians orders, will be the overall coordinator of home health services for the client. This includes consultation and collaboration between all professional staff who are seeing the same client, supervising other nursing staff, and making appropriate referrals as deemed necessary. All other professional staff are obliged to maintain liaison with the Case Manager. Communications between professional staff and Case manager regarding an individual client shall be documented in administrative note or on communication form ... "</p>			

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G000202	484.36 HOME HEALTH AIDE SERVICES Based on personnel record review, policy review, clinical record review, and interview, it was determined the agency failed to ensure the home health aide successfully completed a competency evaluation program before the aide provided care for 3 of 6 home health aide files reviewed (See G 211), failed to ensure the home health aide met the competency evaluation requirement for 3 of 6 home health aide files reviewed (See G 212), failed to ensure the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of this section before the aide provided care for 3 of 6 home health aide files reviewed (See G 213), failed to ensure the home health aide successfully completed a competency evaluation was completed on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section for 3 of 6 home health aide files reviewed (See G 218), failed to ensure documentation evidenced the home health aide	G000202	It is the intent of PHI to ensure the Home Health Aide Services meet the State and Federal Regulations. See G211, G 212, G213, G218, G221, G224, G2229, G230.	02/08/2014
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	<p>successfully completed a competency evaluation program before the aide provided care for 3 of 6 home health aide files reviewed (See G 221), failed to ensure the registered nurse provided care instructions for the home health aides with specific frequencies for 2 of 7 clinical records reviewed with orders for a home health aide (See G 224), failed to ensure the registered nurse completed an on-site supervisory visit of the home health aide every 14 days in 1 of 6 active records reviewed of patients who received skilled and home health aide services longer than 14 days(See G 229), and failed to ensure the registered nurse made a home health aide supervisory visit while the aide was present and providing care to ensure the aide is properly caring for the patient in 1 of 1 clinical records reviewed of patient receiving home health aide only services (See G 230) creating the potential to affect all 42 patients of the agency receiving home health aide services .</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to ensure safe home health aide care was provided as required by the Condition of Participation 484.36: Home Health Aide services.</p>						

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G000211	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph.</p> <p>Based on personnel file review, policy review, and interviews, the agency failed to ensure the home health aides successfully completed a competency evaluation program before the aide provided care for 3 of 6 aide files reviewed with the potential to affect all the patients receiving home health aide services. (C, J, and K)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Personnel record C, date of hire 07/30/13 and first patient contact 08/01/13, evidenced a document titled "Certified Home Health/ Hospice Aide Checklist" signed by the home health aide on 08/02/13 and by the Administrator (Registered Nurse) on 08/01/13, 08/02/13, and 08/05/13. <ul style="list-style-type: none"> Mobility (ambulation, range of motion, transfer and positioning) and fluid balance evidenced skills were met on 08/01/13 in the agency lab. The form 	G000211	<p>It is the intent of PHI to ensure the Home Health Aides have successfully completed a competency evaluation program before the aides provide care. It is the intent of PHI to ensure home health aides successfully complete a competency evaluation program prior to providing patient care. For the two year period of January 17, 2014 through January 17, 2016 an outside contracted RN who has a minimum of two years of nursing experience with at least one year of home health care experience will be recruited to provide the Competency Evaluation Program and the Home Health Aide In-service Training Program for PHI per State and Federal Regulations. The PCC or designee will monitor the Home Health Aide Training and In-service Program for compliance.</p>	02/08/2014			

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	<p>did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair/shampoo) evidenced skills were met on 08/02/13, hair / shampoo by bed on 08/01/13, by sink on 08/02/13, and bathtub on 08/05/13 did not evidenced location but indicated "no problems". The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>c. Vital signs was met on 08/01/13 but indicated "lab only our aides do not take vitals"</p> <p>d. Employee A (Director of Nursing), on 01/03/14 at 3:00 p.m., indicated the skills evaluation were done incorrectly and the task was given to a case manager.</p> <p>2. Personnel record J, date of hire 07/23/13 and first patient contact 07/26/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 07/30/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, nail care,</p>						

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	<p>hair / shampoo, and prevention of skin breakdown), body functions (vital signs, and fluid balance), environmental services (linen change) evidenced the skills were met on 07/26/13. The shower, tub and sponge bath of personal care was met on 07/27/13 and re-tested on 07/30/13 [sic]. The toileting (bathroom, bedpan, urinal bedside commode, and catheter) were met on 07/26/13 and re-tested on 07/30/13 [sic]. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Interview with Employee J (Home Health Aide) on 01/03/14 at 4:00 p.m., indicated the skills evaluation and check off was completed in the agency lab and not in the patient's home.</p> <p>3. Personnel record K, date of hire 09/24/13 and first patient contact 10/03/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 10/03/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair / shampoo, and prevention of skin breakdown), vital signs and fluid</p>			
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	<p>balance evidenced the skills were met on 09/24/13. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>4. A policy titled "Home Health Aide Competency Policy" dated 07/13/12, indicated "Individuals working under the job description of home health aide, must be certified and demonstrate competency prior to being independently placed in the field with clients ... The [Name of Network] Aide Checklist for Skills Demonstration with no more than one unsuccessful area, Evaluation will be administered during initial orientation before independent assignment to clients ... Additional skills required for care will be verified as competent by the referring RN, therapist or PCC (Patient Care Coordinator) prior to independent care being given."</p>			

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G000212	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on personnel record, policy review and interview, the agency failed to ensure the home health aide met the competency evaluation requirement for 3 of 6 aide files reviewed with the potential to affect all the patients receiving home health aide services. (C, J, and K)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel record C, date of hire 07/30/13 and first patient contact 08/01/13, evidenced a document titled "Certified Home Health/ Hospice Aide Checklist" signed by the home health aide on 08/02/13 and by the Administrator (Registered Nurse) on 08/01/13, 08/02/13, and 08/05/13. <ul style="list-style-type: none"> a. Mobility (ambulation, range of motion, transfer and positioning) and fluid balance evidenced skills were met on 08/01/13 in the agency lab. The form did not evidenced if the skill were met with direct care or with a pseudo-patient. b. Personal care (oral, bed bath, 	G000212	It is the intent of PHI to ensure the employees who furnish Home Health Aide services meet competency evaluation requirements. See G 211.	02/08/2014			

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	<p>bath by shower / tub / sponge, nail care, hair/shampoo) evidenced skills were met on 08/02/13, hair / shampoo by bed on 08/01/13, by sink on 08/02/13, and bathtub on 08/05/13 did not evidenced location but indicated "no problems". The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>c. Vital signs was met on 08/01/13 but indicated "lab only our aides do not take vitals"</p> <p>d. Employee A (Director of Nursing), on 01/03/14 at 3:00 p.m., indicated the skills evaluation were done incorrectly and the task was given to a case manager.</p> <p>2. Personnel record J, date of hire 07/23/13 and first patient contact 07/26/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 07/30/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, nail care, hair / shampoo, and prevention of skin breakdown), body functions (vital signs, and fluid balance), environmental services (linen change) evidenced the</p>						

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	<p>skills were met on 07/26/13. The shower, tub and sponge bath of personal care was met on 07/27/13 and re-tested on 07/30/13 [sic]. The toileting (bathroom, bedpan, urinal bedside commode, and catheter) were met on 07/26/13 and re-tested on 07/30/13 [sic]. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Interview with Employee J (Home Health Aide) on 01/03/14 at 4:00 p.m., indicated the skills evaluation and check off was completed in the agency lab and not in the patient's home.</p> <p>3. Personnel record K, date of hire 09/24/13 and first patient contact 10/03/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 10/03/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair / shampoo, and prevention of skin breakdown), vital signs and fluid balance evidenced the skills were met on 09/24/13. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p>						

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G000213	<p>4. A policy titled "Home Health Aide Competency Policy" dated 07/13/12, indicated "Individuals working under the job description of home health aide, must be certified and demonstrate competency prior to being independently placed in the field with clients ... The [Name of Network] Aide Checklist for Skills Demonstration with no more than one unsuccessful area, Evaluation will be administered during initial orientation before independent assignment to clients ... Additional skills required for care will be verified as competent by the referring RN, therapist or PCC (Patient Care Coordinator) prior to independent care being given."</p> <p>484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAINING The competency evaluation must address each of the subjects listed in paragraphs (a)(1)(ii) through (xiii) of this section. Based on personnel record clinical record, and policy review and interview, the agency failed to ensure the home health aide successfully completed a competency evaluation program of sufficient scope and addressed all of the required subjects areas listed at paragraphs (a)(1)(ii) through (xiii) of</p>	G000213	It is the intent of PHI to ensure Home Health Aides successfully complete a competency evaluation program per State regulations. See G211.	02/08/2014			

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	<p>this section before the aide provided care for 3 of 6 aide files reviewed with the potential to affect all the patients receiving home health aide services. (C, J, and K)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel record C, date of hire 07/30/13 and first patient contact 08/01/13, evidenced a document titled "Certified Home Health/ Hospice Aide Checklist" signed by the home health aide on 08/02/13 and by the Administrator (Registered Nurse) on 08/01/13, 08/02/13, and 08/05/13. <ol style="list-style-type: none"> a. Mobility (ambulation, range of motion, transfer and positioning) and fluid balance evidenced skills were met on 08/01/13 in the agency lab. The form did not evidenced if the skill were met with direct care or with a pseudo-patient. b. Personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair/shampoo) evidenced skills were met on 08/02/13, hair / shampoo by bed on 08/01/13, by sink on 08/02/13, and bathtub on 08/05/13 did not evidenced location but indicated "no problems". The form did not evidenced if the skill were met with direct care or with a pseudo-patient. 						

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	<p>c. Vital signs was met on 08/01/13 but indicated "lab only our aides do not take vitals"</p> <p>d. Employee A (Director of Nursing), on 01/03/14 at 3:00 p.m., indicated the skills evaluation were done incorrectly and the task was given to a case manager.</p> <p>2. Personnel record J, date of hire 07/23/13 and first patient contact 07/26/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 07/30/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, nail care, hair / shampoo, and prevention of skin breakdown), body functions (vital signs, and fluid balance), environmental services (linen change) evidenced the skills were met on 07/26/13. The shower, tub and sponge bath of personal care was met on 07/27/13 and re-tested on 07/30/13 [sic]. The toileting (bathroom, bedpan, urinal bedside commode, and catheter) were met on 07/26/13 and re-tested on 07/30/13 [sic]. The form did not evidenced if the skill were met with direct care or with a</p>						

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	<p>pseudo-patient.</p> <p>b. Interview with Employee J (Home Health Aide) on 01/03/14 at 4:00 p.m., indicated the skills evaluation and check off was completed in the agency lab and not in the patient's home.</p> <p>3. Personnel record K, date of hire 09/24/13 and first patient contact 10/03/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 10/03/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair / shampoo, and prevention of skin breakdown), vital signs and fluid balance evidenced the skills were met on 09/24/13. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>4. A policy titled "Home Health Aide Competency Policy" dated 07/13/12, indicated "Individuals working under the job description of home health aide, must be certified and demonstrate competency prior to being independently placed in the field with clients ... The [Name of Network] Aide Checklist for</p>						

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G000218	<p>Skills Demonstration with no more than one unsuccessful area, Evaluation will be administered during initial orientation before independent assignment to clients ... Additional skills required for care will be verified as competent by the referring RN, therapist or PCC (Patient Care Coordinator) prior to independent care being given."</p> <p>484.36(b)(3)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aides performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.</p> <p>Based on personnel record, policy review and interview, the agency failed to ensure the home health aide successfully completed a competency evaluation on a patient or pseudo patient in the subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section for 3 of 6 aide files reviewed with the potential to affect all the patients receiving home health aide services. (C, J, and K)</p>	G000218	It is the intent of PHI to ensure the Home Health Aide completes a competency evaluation on a patient or pseudo patient. See G211.	02/08/2014			

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	<p>The findings include:</p> <p>1. Personnel record C, date of hire 07/30/13 and first patient contact 08/01/13, evidenced a document titled "Certified Home Health/ Hospice Aide Checklist" signed by the home health aide on 08/02/13 and by the Administrator (Registered Nurse) on 08/01/13, 08/02/13, and 08/05/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning) and fluid balance evidenced skills were met on 08/01/13 in the agency lab. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair/shampoo) evidenced skills were met on 08/02/13, hair / shampoo by bed on 08/01/13, by sink on 08/02/13, and bathtub on 08/05/13 did not evidenced location but indicated "no problems". The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>c. Vital signs was met on 08/01/13 but indicated "lab only our aides do not take vitals"</p> <p>d. Employee A (Director of</p>						

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	<p>Nursing), on 01/03/14 at 3:00 p.m., indicated the skills evaluation were done incorrectly and the task was given to a case manager.</p> <p>2. Personnel record J, date of hire 07/23/13 and first patient contact 07/26/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 07/30/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, nail care, hair / shampoo, and prevention of skin breakdown), body functions (vital signs, and fluid balance), environmental services (linen change) evidenced the skills were met on 07/26/13. The shower, tub and sponge bath of personal care was met on 07/27/13 and re-tested on 07/30/13 [sic]. The toileting (bathroom, bedpan, urinal bedside commode, and catheter) were met on 07/26/13 and re-tested on 07/30/13 [sic]. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Interview with Employee J (Home Health Aide) on 01/03/14 at 4:00 p.m., indicated the skills evaluation and check off was completed in the agency</p>						

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	<p>lab and not in the patient's home.</p> <p>3. Personnel record K, date of hire 09/24/13 and first patient contact 10/03/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 10/03/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair / shampoo, and prevention of skin breakdown), vital signs and fluid balance evidenced the skills were met on 09/24/13. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>4. A policy titled "Home Health Aide Competency Policy" dated 07/13/12, indicated "Individuals working under the job description of home health aide, must be certified and demonstrate competency prior to being independently placed in the field with clients ... The [Name of Network] Aide Checklist for Skills Demonstration with no more than one unsuccessful area, Evaluation will be administered during initial orientation before independent assignment to clients ... Additional skills required for care will be verified as competent by the referring</p>						

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G000221	<p>RN, therapist or PCC (Patient Care Coordinator) prior to independent care being given." 484.36(b)(5) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must maintain documentation which demonstrates that the requirements of this standard are met.</p> <p>Based on personnel record, policy review and interview, the agency failed to ensure documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care for 3 of 6 aide files reviewed with the potential to affect all the patients receiving home health aide services. (C, J, and K)</p> <p>The findings include:</p> <p>1. Personnel record C, date of hire 07/30/13 and first patient contact 08/01/13, evidenced a document titled "Certified Home Health/ Hospice Aide Checklist" signed by the home health aide on 08/02/13 and by the Administrator (Registered Nurse) on 08/01/13, 08/02/13, and 08/05/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning) and fluid balance evidenced skills were met on 08/01/13 in the agency lab. The form</p>	G000221	It is the intent of PHI to ensure documentation evidences the home health aide successfully completed a competency evaluation program. See G211.	02/08/2014			

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	<p>did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair/shampoo) evidenced skills were met on 08/02/13, hair / shampoo by bed on 08/01/13, by sink on 08/02/13, and bathtub on 08/05/13 did not evidenced location but indicated "no problems". The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>c. Vital signs was met on 08/01/13 but indicated "lab only our aides do not take vitals"</p> <p>d. Employee A (Director of Nursing), on 01/03/14 at 3:00 p.m., indicated the skills evaluation were done incorrectly and the task was given to a case manager.</p> <p>2. Personnel record J, date of hire 07/23/13 and first patient contact 07/26/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 07/30/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, nail care,</p>				

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	<p>hair / shampoo, and prevention of skin breakdown), body functions (vital signs, and fluid balance), environmental services (linen change) evidenced the skills were met on 07/26/13. The shower, tub and sponge bath of personal care was met on 07/27/13 and re-tested on 07/30/13 [sic]. The toileting (bathroom, bedpan, urinal bedside commode, and catheter) were met on 07/26/13 and re-tested on 07/30/13 [sic]. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Interview with Employee J (Home Health Aide) on 01/03/14 at 4:00 p.m., indicated the skills evaluation and check off was completed in the agency lab and not in the patient's home.</p> <p>3. Personnel record K, date of hire 09/24/13 and first patient contact 10/03/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 10/03/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair / shampoo, and prevention of skin breakdown), vital signs and fluid</p>			

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G000224	<p>balance evidenced the skills were met on 09/24/13. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>4. A policy titled "Home Health Aide Competency Policy" dated 07/13/12, indicated "Individuals working under the job description of home health aide, must be certified and demonstrate competency prior to being independently placed in the field with clients ... The [Name of Network] Aide Checklist for Skills Demonstration with no more than one unsuccessful area, Evaluation will be administered during initial orientation before independent assignment to clients ... Additional skills required for care will be verified as competent by the referring RN, therapist or PCC (Patient Care Coordinator) prior to independent care being given."</p> <p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on the clinical record and policy review, the agency failed to ensure the</p>	G000224	It is the intent of PHI to ensure the registered nurse provides care instructions for the home health aides with specific	02/08/2014			

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	<p>registered nurse provided care instructions for the home health aides with specific frequencies for 2 of 7 clinical records reviewed with orders for a home health aide with the potential to affect all patients who receive home health aide services. (# 9 and 10)</p> <p>The findings include:</p> <p>1. Clinical Record # 9, SOC 09/26/13, included a plan of care for the certification period 09/26/13 to 11/24/13 with physician's orders for home health aide services 0 week 1, 2 times a week for 8 weeks, 0 week 1 beginning during week of 09/26/13. The Home Health Aide care plan revised on 09/26/13, evidenced hygiene (bath, perineal, skin care, oral care, shampoo, shave and dress assist), home management (clean bathroom after patient care), elimination (assist to bedside commode / toilet and empty ostomy bag) to be completed "prn" (as needed). There were no specific frequencies identified that the aide was to provide the care.</p> <p>2. Clinical record # 10, SOC 06/03/13, included a plan of care for the certification period 10/01/13 to 11/29/13 with physician's orders for home health aide services 1 time a week for week and 1 and 2 times a week for 8 weeks</p>		<p>frequencies. It is the intent of PHI to ensure the RN delegates duties and tasks to LPN's and other individuals as appropriate. The Case Managers will document the frequency of visits as ordered or note per request of patient/caregiver per authorization on the hygiene screen under "other" of the home health aide assignment sheet in the clinical software program. The Home Health Aide Scheduler (HHAS) will monitor each aide assignment sheet she receives from the case managers and inform the case managers if frequency is not noted and return for correction. The HHAS will inform the PCC of any non-compliance for follow up with the case managers.</p>				

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	<p>per Medicare with skilled nursing supervision per Medicare guidelines beginning the week of 10/01/13. The Home Health Aide Care Plan indicated hygiene prn with warm soaks and gentle massage of hands, ambulate only with assistance of a walker prn, ROM (range of motion) exercises prn to the arms and legs, and follow exercise plan. The comment / note section indicated hand weights as patient tolerates, 5 minutes with exercise bike as patient tolerates. The care plan evidenced to encourage high calorie snacks, clean up kitchen after meal preparation and clean bathroom after patient care prn. There were no specific frequencies identified that the aide was to provide the care.</p> <p>3. A policy titled "Home Health Aide Services) dated 06/05/13, indicated "Home health aide services will be provided to clients in a safe manner ... The home health aide's primary function under Medicare is to provide personal care ...Assistance with walking simple exercise program approved by nurse, or therapist .."</p>				

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G000229	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse completed an on-site supervisory visit of the home health aide every 14 days in 1 of 6 (# 4) active records reviewed of patients who received skilled and home health aide services longer than 14 days with the potential to affect all the patients of the agency receiving home health aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 4, start of care 7/23/13, included a plan of care for the certification period 11/20/13 to 1/18/14 with orders for skilled nurse and home health aide services. The record evidenced a registered nurse supervisory visit was made 11/13/13 and 12/4/13, a period of more then 14 days. 2. On 1/8/14 at 10:41 AM, employee G, a registered nurse, indicated she made a supervisory visit on 12/26/13 and that there was no documentation to evidence that visit was made. 	G000229	It is the intent of PHI to ensure the RN completes an on-site supervisory visit of the aide every 14 days. See G160.	02/08/2014			

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G000230	<p>484.36(d)(3) SUPERVISION</p> <p>If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse made a home health aide supervisory visit while the aide was present and providing care to ensure the aide is properly caring for the patient in 1 of 1 clinical records reviewed of patient receiving home health aide only services creating the potential to affect all 42 patients of the agency receiving home health aide services. (# 8)</p> <p>Findings include:</p> <p>1. Clinical record 8, start of care 11/5/13 evidenced a plan of care dated 11/5/13 through 1/3/14 with orders for home health aide services only. The record failed to evidence a registered nurse conducted a supervisory while the aide was providing care.</p>	G000230	The Case Managers and Field Nurses will be in-serviced on the regulation requiring an RN make a home health aide supervisory visit while the aide is present and providing patient care no less frequently than every 60 days. The Case Managers and RN Field Nurses will document the patient care observed while supervising a home health aide. The Quality Improvement RN or designee will track the timelessness of the supervisory visits made and the documentation of patient care observed. Non-compliance will be reported to the Case Manager for correction. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014	

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G000235	<p>The record evidenced one supervisory visit was made on 11/26/13. The documentation failed to evidence the aide was present in the home and providing care during the supervisory visit.</p> <p>2. On 1/8/13 at 10:15 AM, employee B indicated agency did not have documentation that the aides were observed and supervised while they provided care. She indicated the aide was not present during the visit.</p> <p>484.48 CLINICAL RECORDS Based on clinical record and policy review and interview, it was determined the agency failed to ensure clinical visits were documented timely and incorporated into the clinical record timely as required by agency policy in 4 of 11 clinical records reviewed creating the potential to affect all the agency's patients (See G 236).</p> <p>The cumulative effect of these systemic problems resulted in the agency be unable to meet the requirements of the</p>	G000235	It is the intent of PHI to ensure clinical visits are documented timely and incorporated into the clinical record timely. See G236.	02/08/2014			

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G000236	<p>Condition of Participation 42 CFR 484.48 Clinical Records.</p> <p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure clinical visits were documented timely and incorporated into the clinical record timely and within 10 days per agency policy in 4 of 11 (1, 5, 9, and 10) clinical records reviewed creating the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. On 12/30/13 at 9:30 AM, the director of nursing indicated during the entrance conference that the skilled nurse visit notes were to be completed by the Monday following the week in which</p>	G000236	The Case Managers will be in-serviced on the regulations for timely documentation of visit notes and OASIS completion. The "Client Clinical Record Filing System" policy and procedure will be revised and reviewed during the in-service. The Case Managers have been counseled and an Employee Conference Record placed in their personnel files. The Quality Improvement RN will monitor for timely visit note documentation and auditing the certification time points for complete and accurate documentation. Non-compliance will be referred to the Case Managers for correction. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014

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	<p>the visit was made and that admission assessments were to be completed within five days.</p> <p>2. Clinical record #5, start of care 11/26/13, included a physician's plan of care for certification period 11/26/13 to 1/24/14 and contained orders for skilled nursing services to teach the primary caregiver intravenous infusion skills using a peripherally inserted central catheter (PICC), PICC dressing changes, lab draws via the PICC and catheter care, and troubleshooting. The clinical record evidenced:</p> <p>A. Employee G conducted an assessment on 11/26/13 and infused antibiotics intravenously via the PICC. The documented evidenced the clinician did not complete the documentation and sign the assessment until 12/6/13, 10 days after the visit was completed.</p> <p>B. A skilled nurse visit note dated 11/27/13 at 4 AM evidenced employee G educated the caregiver on IV antibiotic administration via the PICC, performed catheter line care, and assessed the patient. The document evidenced the clinician did not complete the documentation and sign the assessment until 12/13/13, 16 days after the visit was completed.</p>						

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	<p>C. A skilled nurse visit note dated 11/27/13 at 10 AM evidenced employee G educated the caregiver on IV antibiotic administration, observed the caregiver perform the antibiotic infusion, and assessed the patient. The document evidenced the clinician did not complete the documentation and sign the assessment until 12/13/13, 16 days after the visit was completed.</p> <p>D. A skilled nurse visit note dated 11/27/13 at 3:55 PM evidenced employee G educated the caregiver on IV antibiotic administration and assessed the patient. The document evidenced the clinician did not complete the documentation and sign the assessment until 12/13/13, 16 days after the visit was completed.</p> <p>E. A skilled nurse visit note dated 11/29/13 at 5:45 PM evidenced employee G withdrew blood sample for labs including a trough, changed the end caps and flushed both lumens with heparin and saline, and and assessed the patient. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/13/13, 14 days after the visit was completed.</p>						

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	<p>F. A skilled nurse visit note dated 12/2/13 at 12:10 PM evidenced employee G assessed the patient and infused an antibiotic intravenously and flushed the PICC with heparin and saline. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/13/13, 11 days after the visit was completed.</p> <p>G. A skilled nurse visit note dated 12/2/13 at 6:15 PM evidenced employee G assessed the patient, withdrew blood sample for labs and included an antibiotic trough, performed PICC line care, and flushed the patients PICC line with heparin and saline. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/13/13, 11 days after the visit was completed.</p> <p>H. A skilled nurse visit note dated 12/3/13 at 12 PM evidenced employee G assessed the patient. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/13/13, 10 days after the visit was completed.</p> <p>I. A skilled nurse visit note dated 12/4/13 at 12 PM evidenced employee G assessed the patient and performed PICC</p>						

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	<p>line care and flushed the patients PICC line with heparin and saline. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/23/13, 19 days after the visit was completed.</p> <p>J. A skilled nurse visit note dated 12/5/13 at 12 PM evidenced employee G assessed the patient, performed PICC line care, and flushed port with heparin and saline. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/23/13, 18 days after the visit was completed.</p> <p>K. A skilled nurse visit note dated 12/7/13 at 3:10 PM failed to evidence any care was provided nor an assessment on the patient. Employee B completed and signed the visit note on 12/20/13, 13 days after the visit was completed.</p> <p>L. A skilled nurse visit note dated 12/11/13 at 2:20 PM evidenced employee G removed the PICC line and dressed the access site. Employee G completed and signed the visit note on 12/23/13, 12 days after the visit was completed.</p> <p>3. On 1/9/14 at 12 PM, employee B indicated the facility did not have a</p>				

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	<p>written policy to guide staff as to how much time should lapse between the time services are provided and how soon the staff are to document and sign their visit notes.</p> <p>4. The agency policy titled "Client Clinical Record Filing System" number 13.4 effective date 9/04 states, "Filing is kept timely. All documentation is filed within 10 working days of submission."</p> <p>5. Clinical record # 1, SOC (start of care) 03/18/13, evidenced:</p> <p>a. A nursing visit note indicated the date of visit was on 10/11/13. The note was entered into the electronic medical record on 11/01/13.</p> <p>b. A nursing visit note indicated the date of visit was on 11/04/13. The note was entered into the electronic medical record on 12/05/13.</p> <p>c. A nursing visit note indicated the date of visit was on 11/27/13. The note was entered into the electronic medical record on 12/19/13.</p> <p>d. A nursing visit note indicated the date of visit was on 12/07/13. The note was entered into the electronic medical record on 12/20/13.</p>				

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	<p>e. A nursing visit note indicated the date of visit was on 12/09/13. The note was entered into the electronic medical record on 12/20/13.</p> <p>6. Clinical record # 9, SOC 09/26/13, evidenced lab requisitions dated 09/30/13, 10/03/13, 10/14/13, 10/21/13, 10/24/13, and 10/31/13. There was no evidence of the laboratory results in the clinical record.</p> <p>a. A nursing visit note indicated the date of visit was on 10/07/13. The note was entered into the electronic medical record on 10/25/13.</p> <p>b. A nursing visit note indicated the date of visit was on 10/16/13. The patient was discharged on 11/04/13. The note was entered into the electronic medical record on 11/08/13.</p> <p>c. A nursing visit note indicated the date of visit was on 10/17/13. The patient was discharged on 11/04/13. The note was entered into the electronic medical record on 11/08/13.</p> <p>d. A nursing visit note indicated the date of visit was on 10/28/13. The patient was discharged on 11/04/13. The note was entered into the electronic</p>						

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	<p>medical record on 11/20/13.</p> <p>e. A nursing visit note indicated the date of visit was on 10/31/13. The patient was discharged on 11/04/13. The note was entered into the electronic medical record on 11/20/13.</p> <p>f. A nursing visit note indicated the date of visit was on 11/04/13. The patient was discharged on 11/04/13. The note was entered into the electronic medical record on 11/21/13.</p> <p>7. Clinical Record # 10, SOC 06/03/13, evidenced:</p> <p>a. A recertification oasis indicated the date of visit was on 09/30/13. There was no date of entry indicated in the signature box.</p> <p>b. A nursing visit note indicated the date of visit was on 10/03/13. The note was entered into the electronic medical record on 10/17/13.</p> <p>c. A nursing visit note indicated the date of visit was on 11/04/13. The note was entered into the electronic medical record on 11/25/13.</p> <p>d. A discharge oasis indicated the date of visit was on 11/20/13. There</p>				

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G000249	<p>was no date of entry indicated in the signature box.</p> <p>8. Employee A (Director of Nursing), on 01/04/13 at 11:45 p.m., indicated the nursing computers did not generally go into the patient's home. Employee A indicated the Administrator would want the visits in the record within 7 days. Employee A indicated the lab results should had been obtained from the laboratory and placed in the chart.</p> <p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW Mechanisms are established in writing for the collection of pertinent data to assist in evaluation. Based on policy and administrative document review and interview, the agency failed to ensure mechanisms were established in writing for the collection of pertinent data to assist in evaluation for 1 of 1 agency with the potential to affect all patients served by the agency.</p> <p>Findings include:</p> <p>1. Review of the agency's policies failed to evidence mechanisms were</p>	G000249	The two action plans concerning home health aide in-service requirements and documentation guidelines for admissions will be discussed at the January Quality Improvement meeting and monitoring re-instituted as appropriate. PHI Quality Improvement monitoring tools will be corrected to include problems found as well as noting errors that were corrected. Home Health Compare and HHQI will be utilized to develop Quality Improvement monitoring that will address identified problems,	02/08/2014

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	<p>established in writing for the collection of pertinent data to assist in evaluation.</p> <p>2. The policy titled "Quality Improvement Program" number 14.1 effective date 8/96 stated, "It is the policy ... to develop, implement, maintain, evaluate and revise a quality assessment and performance improvement program on an on-going basis. The Quality Control Committee will coordinate and summarize all quality improvement activities. Purpose: ... To review services delivered against established standards for aspects of care determined as high risk, high volume, and problem prone services. To involve professional staff in evaluating aspects of care against established standards. ... Procedure: The Quality Control Committee (ACC) ... will develop indicators of best practices ... which will be the standard use as target goals. ... The Quality Improvement Program will be reviewed, evaluated for effectiveness and revised as needed annually. This annual evaluation will be documented in the QCC meeting minutes."</p> <p>3. Administrative documents titled "PHI QI Agenda" dated 7/15/13 evidenced two action plans were in place: one was related to home health aide in-service</p>		<p>objective measurements, and improve performance across the spectrum of care. An action plan proposal will be presented to the Quality Control Committee in February 2014. The Infection Control Committee will research and develop a policy/procedure concerning cleaning and disinfection of patient care equipment used in the home and staff will be in-serviced in February 2014. Supplies have been ordered to bring PHI into compliance. Also a Briggs Home Health Agency Clinical Manual has been ordered for reference. This in-service will include the policy and procedure on hand hygiene. The need for periodic peer to peer review, observation or refresher labs for agency staff will be discussed at the January Quality Improvement Meeting and a subcommittee assigned to develop such a program per action plan. The Action Plans will be reviewed monthly by the Quality Care Committee during the Quality Improvement Meeting and interventions and revisions made as needed. The Quality Improvement RN will work with the Quality Care Committee in developing action plans to address and identify patient and agency problem prone services. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.</p>				

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	<p>requirements and the other was documentation guidelines for admissions. The documentation acknowledged four patients with infections and referred to the infection log.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the PHI [Physician's HomeCare Inc.] folder in the home and the presence of the aide assignment sheet.</p> <p>4. Administrative documents titled "PHI QI Agenda" dated 8/12/13 evidenced two action plans were in place: one was related to home health aide in-service requirements and the other was documentation guidelines for admissions. The documentation acknowledged two patients with infections, indicated chart audits of newly admitted patients and discharged patients identified problems. The document did not reveal the problems identified, just that errors were corrected.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records</p>						

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	<p>for these 10 patients were reviewed for documentation of the presence of the PHI folder in the home and the presence of the aide assignment sheet.</p> <p>5. Administrative documents titled "PHI QI Agenda" dated 9/16/13 evidenced two action plans were in place: one was related to home health aide in-service requirements and the other was documentation guidelines for admissions. The documentation acknowledged three patients were admitted with infections from hospital.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the PHI folder in the home and the presence of the aide assignment sheet.</p> <p>6. Administrative documents titled "PHI QI Agenda" dated 10/28/13 acknowledged five patients admitted with infections and one patient had a reoccurring infection.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the</p>				

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	<p>PHI folder in the home and the presence of the aide assignment sheet.</p> <p>7. On 1/3/14 at 2:35 PM, employee A indicated there was no meeting for the November information, that there was no active and current Action Plans since July 2013, and the only other information she had to provide was related to the difficulty communicating with the Veteran's Administration on behalf of their VA patients.</p> <p>8. Review of administrative documents include logs tiled "Infection Report" that evidenced as follows:</p> <p>A. The report dated July 2013 evidenced 7 patients with infections; two patients were treated for a urinary tract infection, one patient with clostridium difficile, one patient treated for an upper respiratory infection, and one patient treated for acute bronchitis.</p> <p>B. The report dated August 2013 evidenced three patients with infections, one listed as sepsis, one with a chest wall infection, and one with a urinary tract infection.</p> <p>C. The report dated September 2013 evidenced one patient was treated for a upper respiratory infection, three for</p>			

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	<p>urinary tract infections, one wound infection and one patient, # 9, listed as "massive infection ... treated with IV ATB [antibiotics]."</p> <p>D. The report dated October 2013 evidenced two patients were treated for a urinary infection.</p> <p>E. The report dated November 2013 evidenced patient 5 was treated for a sinus infection and a trachea infection, patient 1 was treated for a wound infection, and another patient was treated for an infection of the ankle (the log is not specific to the infection).</p> <p>F. The report dated December 2013 included 9 patients with infections, four patients were treated for a urinary tract infection, one of which was patient 1, one patient with a wound infection, one patient was listed as sepsis, one respiratory infection, and one of the nine was patient 3 with cellulitis of the foot.</p> <p>8. On 1/8/14 at 12 PM, employee N indicated the agency did not have a written policy or procedure for how the staff were to maintain infection control during the provision of care in the patient's home; she indicated she hired professionals.</p>						

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G000250	<p>484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.</p> <p>Based on agency quality assurance document review and interview, the agency failed to ensure all disciplines had participated in the clinical record audits for 4 of 4 months reviewed, (July, August, September, and October 2013) reviewed creating the potential to affect all of the agency's 173 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During the entrance conference on 12/30/13 at 9:30 AM, employee A, the director of nursing, indicated the agency provided skilled nursing services, traditional one hour visits, and extended hours to adults and pediatric patients; home health aide services with skilled and aide only; and physical and occupational therapy services through two contracted companies. 2. Clinical record audit documents July through October 2013 failed to evidence any physical and occupational therapists 	G000250	It is the intent of PHI to ensure all disciplines participate in the clinical record audit. The MRC will continue to monitor all admission and discharge records. The PCC will continue to follow up on clinical record problems identified by the MRC monitoring. These clinical records and the problem resolutions will continue to be documented on the Case Record Review form that is contained in a three ring binder in the PCC office. A policy and procedure will be written to address the participation of all disciplines in the clinical record audit and the clinical staff will be in-serviced. The PCC or designee will coordinate and monitor the therapists' participation.	02/08/2014			

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G000322	<p>had participated in the clinical record review audits.</p> <p>3. Employee A, indicated, on 1/3/14 at 2:35 PM, the only record review was as provided in the quality improvement documentation and indicated the clinical record review looked for documentation of the presence of the Physician's HomeCare Inc. folder in the home and the presence of the aide assignment sheet. She further indicated she did not have any further data, in any format, for review for the months November and December 2013.</p> <p>484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on clinical record review and interview, the agency failed to ensure Oasis data accurately reflected the patient's status at the time of an assessment for 1 of 7 records reviewed that required OASIS items to be assessed (# 10) with the potential to affect all patients.</p> <p>Finding include: Clinical Record # 10, SOC (start of care) 06/03/13, with physician plan of care</p>	G000322	Both Case Managers have been counseled and an Employee Conference Record has been placed in their personnel file emphasizing that the RN completing an OASIS assessment must have completed the assessment visit. The Quality Improvement RN will be monitoring the certification time points for complete and accurate documentation. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014			

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	<p>orders 10/1/13 to 11/29/13.</p> <p>a. Clinical record evidenced a form "Alteration in Visit Frequency" dated 09/30/13 that stated, "Supervisory of aide was rescheduled for 10/03/13 per request of spouse due to B12 injection schedule."</p> <p>b. Clinical record evidenced a Recertification Oasis dated 09/30/13 at 8:00 a.m., signed by the Employee B. The clinical record failed to evidence an assessment had been completed.</p> <p>c. Employee B was interviewed on 12/31/13 at 4:00 p.m. Employee B indicated she did not perform a nursing visit / assessment on 09/30/13. Employee B indicated the visit was made on 10/03/13 due to a monthly injection. Employee B indicated she had completed the Oasis items without an assessment.</p>				

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G000340	<p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.</p> <p>Based on policy and record review, observation, and interview, the home health agency failed to ensure the comprehensive assessment was updated and revised after the patient returned home from the hospital in 1 of 11 clinical records reviewed with the potential to affect all patients of the agency. (#3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency policy titled "Physician's Plan of Care Policy" dated 9/04 stated, "Upon resumption of PHI [Physician HomeCare, Inc.] services, a Reassessment is completed on the first visit following institutionalization. The plan of care ... are reviewed for necessary revisions." 2. Clinical record # 3, start of care 11/14/13, had diagnoses of chronic renal failure and Diabetes mellitus. The record contained a plan of care 	G000340	The Case Manager's and RN Field Nurses have been counseled and an Employee Conference Record place in their personnel files. An in-service will be given to review the regulations for timely OASIS completion and complete and accurate assessment at each time point. The Quality Improvement RN will be monitoring the certification time points for complete and accurate documentation. Any non-compliance will be referred to the Cases Manager's for correction. The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014			

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	<p>for the certification period 11/14/13 through 1/13/14 with orders for skilled nursing once a week for eight weeks and a home health aide twice a week. The record evidenced the aide reported blisters on the patient's feet on 12/5/13.</p> <p>A. The skilled nurse visit note dated 12/6/13 evidenced documentation of a skin assessment which included on the right foot: 1) A fluid filled blister on the top of the foot that measured 0.5 centimeters (cm) length and 3.4 cm width, 2) A blister on the lateral outer aspect that was fluid filled and measured 4.6 cm length and 3.7 cm width, 3) A black eschar blister to the lateral side of the small toe that measured 0.6 cm length and 0.4 cm width, 4) A blood blister on the bottom of the small toe that measured 1.2 cm length and 1.0 cm width, 5) A blood blister on the under side of the second toe that measured 1.0 cm length and 1.5 cm width; and 6) A crescent shaped open area on the top of the second toe measured 0.5 cm length and 0.2 cm width. Blisters on the left foot included one that measured 0.2 cm length and 0.4 cm width located on the tip of the fifth toe and an open blister on the top of the fourth toe</p>				

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	<p>that measured 0.5 cm length and 1.1 cm width. The nurse note evidenced both feet with pitting edema of +3. The attending physician was contacted and the patient was admitted to the hospital and treated for cellulitis.</p> <p>B. The patient was discharged to home on on 12/8/13. The record evidenced employee B completed a resumption of care comprehensive assessment on 12/9/13 that was incomplete. The assessment failed to include a skin assessment that included the status and condition of the patient's skin and the condition of the previous blisters on the patient's feet.</p> <p>C. The record evidenced a skilled nurse visit was completed by employee L on 12/10/13 to assess wounds of the feet. The visit documentation evidenced a blister was intact on the right foot, outer aspect. No reference to any other skin issue was documented within the visit note.</p> <p>D. On 1/8/14 at 11:15 AM, employee B indicated all of the patient's skin lesions and wounds should be documented and monitored.</p>				

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N000000	<p>This visit was a home health state re-licensure survey.</p> <p>Survey dates: December 30 and 31, 2013, and January 2, 3, and 8, 2014</p> <p>Facility #005352</p> <p>Medicaid Vendor: # 100265450A</p> <p>Surveyors: Bridget Boston, RN, PH Nurse Surveyor, Team Leader Shannon Pietraszewski RN, PH Nurse Surveyor, Team Member</p> <p>Census: 173 Home Visits: 6</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 17, 2014</p>	N000000					

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N000456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on administrative document and policy review, observation, and interview, the administrator failed to ensure the ongoing quality assurance and performance improvement program was designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolved identified problems, improved patient care, and included infection control monitoring for 1 of 1 agency reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. The policy titled "Quality Improvement Program" number 14.1 effective date 8/96 stated, "It is the policy ... to develop, implement, maintain, evaluate and revise a quality assessment and performance improvement program on an on-going</p>	N000456	It is the intent of PHI to ensure and maintain the ongoing Quality Assurance and Performance Improvement Program. The two action plans concerning home health aide in-service requirements and documentation guidelines for admissions will be discussed at the January Q.I. meeting and monitoring re-instituted as appropriate. PHI Q.I. monitoring tools will be corrected to include problems found as well as noting errors that were corrected. Home Health Compare and HHQI will be utilized to develop QI monitoring that will address identified problems, objective measurements, and improve performance across the spectrum of care. An action plan proposal will be presented to the Quality Control Committee (QCC) in February 2014. The Infection Control Committee will research and develop a policy/procedure concerning cleaning and disinfection of patient care equipment used in the home and	02/08/2014			

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	<p>basis. The Quality Control Committee will coordinate and summarize all quality improvement activities. Purpose: ... To review services delivered against established standards for aspects of care determined as high risk, high volume, and problem prone services. To involve professional staff in evaluating aspects of care against established standards. ... Procedure: The Quality Control Committee (ACC) ... will develop indicators of best practices ... which will be the standard use as target goals. ... The Quality Improvement Program will be reviewed, evaluated for effectiveness and revised as needed annually. This annual evaluation will be documented in the QCC meeting minutes."</p> <p>2. Administrative documents titled "PHI QI Agenda" dated 7/15/13 evidenced two action plans were in place: one was related to home health aide in-service requirements and the other was documentation guidelines for admissions. The documentation acknowledged four patients with infections and referred to the infection log.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records</p>		<p>staff will be in-serviced in January and February 2014. Supplies have been ordered to bring PHI into compliance. Also a Briggs Home Health Agency Clinical Manual has been ordered for reference. This inservice will include the policy and procedure on hand hygiene. The need for periodic peer to peer review, observation or refresher labs for agency staff will be discussed at the January QI Meeting and a subcommittee assigned to develop such a program per action plan. The Action Plans will be reviewed monthly by the QCC during the QI Meeting and interventions and revisions made as needed.</p>		

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	<p>for these 10 patients were reviewed for documentation of the presence of the PHI [Physician's HomeCare Inc.] folder in the home and the presence of the aide assignment sheet.</p> <p>3. Administrative documents titled "PHI QI Agenda" dated 8/12/13 evidenced two action plans were in place: one was related to home health aide in-service requirements and the other was documentation guidelines for admissions. The documentation acknowledged two patients with infections, indicated chart audits of newly admitted patients and discharged patients identified problems. The document did not reveal the problems identified, just that errors were corrected.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the PHI folder in the home and the presence of the aide assignment sheet.</p> <p>4. Administrative documents titled "PHI QI Agenda" dated 9/16/13 evidenced two action plans were in place: one was related to home health aide in-service requirements and the other was</p>				

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	<p>documentation guidelines for admissions. The documentation acknowledged three patients were admitted with infections from hospital.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the PHI folder in the home and the presence of the aide assignment sheet.</p> <p>5. Administrative documents titled "PHI QI Agenda" dated 10/28/13 acknowledged five patients admitted with infections and one patient had a reoccurring infection.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the PHI folder in the home and the presence of the aide assignment sheet.</p> <p>6. On 1/3/14 at 2:35 PM, employee M indicated there was no meeting for the November information, that there was no active and current Action Plans since July 2013, and the only other information she had to provide was related to the difficulty communicating</p>				

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	<p>with the Veteran's Administration on behalf of their VA patients.</p> <p>7. Review of administrative documents include logs titled "Infection Report" that evidenced as follows:</p> <p>A. The report dated July 2013 evidenced 7 patients with infections; two patients were treated for a urinary tract infection, one patient with clostridium difficile, one patient treated for an upper respiratory infection, and one patient treated for acute bronchitis.</p> <p>B. The report dated August 2013 evidenced three patients with infections, one listed as sepsis, one with a chest wall infection, and one with a urinary tract infection.</p> <p>C. The report dated September 2013 evidenced one patient was treated for a upper respiratory infection, three for urinary tract infections, one wound infection, and one patient, # 9, listed as "massive infection ... treated with IV ATB [antibiotics]."</p> <p>D. The report dated October 2013 evidenced two patients were treated for a urinary infection.</p> <p>E. The report dated November 2013</p>						

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	<p>evidenced patient 5 was treated for a sinus infection and a trachea infection, patient 1 was treated for a wound infection and another patient was treated for an infection of the ankle (the log is not specific to the infection).</p> <p>F. The report dated December 2013 included 9 patients with infections, four patients were treated for a urinary tract infection, one of which was patient 1, one patient with a wound infection, one patient was listed as sepsis, one respiratory infection, and one of the nine was patient 3 with cellulitis of the foot.</p> <p>8. During a home visit on 12/31/13 at 12:45 PM, employee B, a registered nurse, failed to demonstrate and observe standard universal precautions during the provision of care with patient 3 as follows:</p> <p>A. The employee carried into the home 2 bags, one black cloth like bag that resembled a purse and one plastic disposable bag, and one clipboard which were placed on the floor without a barrier beside the patient's recliner. She failed to complete hand hygiene after entering the home and before rendering any care. The black cloth bag contained a blood pressure cuff, stethoscope, and a standard blue handled utility home</p>						

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	<p>scissors that were co-mingled and without barriers between the items or between the items and the inside lining of the bag. The second bag was a plastic grocery bag with individually wrapped gauze and syringes and other wrapped supplies.</p> <p>B. The employee withdrew the blood pressure cuff and a stethoscope from the black bag and placed the cuff on the patient's right wrist. After assessing the patient's blood pressure, she returned the cuff to the cloth bag among the other equipment and did not decontaminate or maintain separate from the other supplies. She then used her stethoscope and placed over clothing on the patients back and chest. Following assessment, she returned the stethoscope to the black bag without decontaminating or maintaining separately from the other supplies.</p> <p>C. Then employee donned a pair of blue gloves and obtained the scissors from the black bag, sat on the floor and began to cut the gauze dressing, and removed the dressing from the patient's right foot. Once the dressing was removed, she placed the dressing and the scissors on the floor to her right and then brushed her hair from her face three times with the same gloved hands. She</p>						

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	<p>then obtained a basin of water from the home; she washed and dried the patient's right foot and noted the three dark dry scabbed wounds on the patient's little toe and three dry scabbed wounds on the second toe. She then washed and dried the left foot; the skin of the left foot was intact. While wearing the same gloves she dressed the right foot with dry gauze; she had gauze left and returned it to the manufacturer's packaging placed on the floor with the soiled dressing, then applied the patient's footwear. While continuing to wear the same gloves, she picked up the soiled dressing from the floor, the remainder of the unused gauze, and the blue handled scissors. While holding all of these items, she placed the scissors into the black bag without decontamination, the remainder of the dressing she placed with the patient's supplies, and the soiled dressing she disposed of in the trash. Then she removed her gloves; she did not complete hand hygiene and brushed her hair from her face.</p> <p>D. Following the dressing change employee B prepared to administer a vitamin B 12 injection and obtain a blood specimen. She placed a chair beside the patient and sat down and completed hand hygiene. She removed a single dose vial of vitamin B 12 from a</p>						

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	<p>plastic Ziploc style bag which contained a prescription label. She removed the manufacturer's seal from the top of the vial exposing the rubber septum, then placed the vial on the fabric arm rest of the patient's recliner. There was no barrier on the arm rest. The patient noted the vial and picked it up and held it. The employee removed a syringe from its manufacturer's sealed package, took the vial from the patient's hand, and again placed the vial in the same location on the arm rest. She then removed the sleeve cover from needle and attempted to puncture the rubber septum; she had not cleansed the top of the vial once the patient had handled the vial. The tip of the needle missed the rubber septum and struck the metal top surrounding the septum, she attempted again and punctured through the rubber septum of the vial and withdrew the contents. She then placed the cap of the needle on the same arm rest of the patient's recliner without a barrier and inserted the needle back into the cap to cover the needle and the syringe that remained on the arm rest capped. She then donned gloves, opened a alcohol wipe, chose the site for the injection, wiped the area with one wipe from north to south direction, removed the cap from the syringe, and administered the vitamin B 12 to the patient in the right</p>			

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	<p>upper extremity.</p> <p>E. She then brushed her hair away from her face with both hands as she continued to wear the same gloves. Her clipboard was on the floor was then moved to her lap. She then retrieved from her black bag on the floor a Ziploc style bag which contained supplies for collecting a blood sample. She emptied the contents from the bag onto her clipboard. She decided which supplies she needed and returned the extra back to the plastic bag and placed it in the black bag. With her right gloved hand, she brushed her hair away from her face, applied the tourniquet to the patient's right arm which was laying on the fabric covered arm rest without a barrier, opened an alcohol wipe and wiped the skin at the right antecubital area once in a downward motion, and then placed the needle into a vein and began to fill three laboratory tubes with blood. After collecting the blood samples and still wearing the same gloves, she pulled a cell phone from her left pocket, looked at the face, returned it to her pocket, wrote on the labels of the blood samples, returned her pen to her pocket, and secured the samples in a Ziploc style bag. She then removed her gloves; no hand hygiene was completed. She collected and placed trash in a receptacle</p>						

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	<p>and left the home without completing hand hygiene and holding the Ziploc bag containing the blood samples.</p> <p>F. An interview was conducted with the employee following the home visit; she indicated that the bag she was carrying was used to carry her supplies for work and indicated she did not have anything to use as a barrier with her. She indicated she would bring a barrier to the home and use if the home was dirty. She indicated she did have alcohol wipes to clean her supplies and that she would clean them before her next visit.</p> <p>G. On 1/8/14 at 11:37 AM, employee B indicated the agency did not have a specific policy(s) and procedure(s) regarding infection control practices the staff were to observe and practice while providing services in the home. She indicated the agency staff were to follow the infection control guidelines per the Centers for Disease Control and she did observe for breaches of infection control procedures in the home during supervisory visits. There was no documentation to support the agency assessed or monitored for infection control nor was there periodically peer to peer review or observation or refresher labs for the</p>						

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N000472	<p>agency staff.</p> <p>H. On 1/8/14 at 12 PM, employee N indicated the agency did not have a written policy or procedure for how the staff were to maintain infection control during the provision of care in the patient's home; she indicated she hired professionals.</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 on administrative document and policy review, observation, and interview, the administrator failed to ensure the ongoing quality assurance and performance improvement program was designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient</p>	N000472	It is the intent of PHI to ensure an ongoing Quality Assurance and Performance Improvement Program. Please see N456 Plan of Correction	02/08/2014			

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	<p>care, resolved identified problems, improved patient care, and included infection control monitoring for 1 of 1 agency reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. The policy titled "Quality Improvement Program" number 14.1 effective date 8/96 stated, "It is the policy ... to develop, implement, maintain, evaluate and revise a quality assessment and performance improvement program on an on-going basis. The Quality Control Committee will coordinate and summarize all quality improvement activities. Purpose: ... To review services delivered against established standards for aspects of care determined as high risk, high volume, and problem prone services. To involve professional staff in evaluating aspects of care against established standards. ... Procedure: The Quality Control Committee (ACC) ... will develop indicators of best practices ... which will be the standard use as target goals. ... The Quality Improvement Program will be reviewed, evaluated for effectiveness and revised as needed annually. This annual evaluation will be documented in the QCC meeting minutes."</p>			

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	<p>2. Administrative documents titled "PHI QI Agenda" dated 7/15/13 evidenced two action plans were in place: one was related to home health aide in-service requirements and the other was documentation guidelines for admissions. The documentation acknowledged four patients with infections and referred to the infection log.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the PHI [Physician's HomeCare Inc.] folder in the home and the presence of the aide assignment sheet.</p> <p>3. Administrative documents titled "PHI QI Agenda" dated 8/12/13 evidenced two action plans were in place: one was related to home health aide in-service requirements and the other was documentation guidelines for admissions. The documentation acknowledged two patients with infections, indicated chart audits of newly admitted patients and discharged patients identified problems. The document did not reveal the problems identified, just that errors were</p>				

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	<p>corrected.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the PHI folder in the home and the presence of the aide assignment sheet.</p> <p>4. Administrative documents titled "PHI QI Agenda" dated 9/16/13 evidenced two action plans were in place: one was related to home health aide in-service requirements and the other was documentation guidelines for admissions. The documentation acknowledged three patients were admitted with infections from hospital.</p> <p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the PHI folder in the home and the presence of the aide assignment sheet.</p> <p>5. Administrative documents titled "PHI QI Agenda" dated 10/28/13 acknowledged five patients admitted with infections and one patient had a reoccurring infection.</p>				

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	<p>An attached form titled "Quality Improvement Report Form" listed 10 patient names and indicated the records for these 10 patients were reviewed for documentation of the presence of the PHI folder in the home and the presence of the aide assignment sheet.</p> <p>6. On 1/3/14 at 2:35 PM, employee M indicated there was no meeting for the November information, that there was no active and current Action Plans since July 2013, and the only other information she had to provide was related to the difficulty communicating with the Veteran's Administration on behalf of their VA patients.</p> <p>7. Review of administrative documents include logs titled "Infection Report" that evidenced as follows:</p> <p>A. The report dated July 2013 evidenced 7 patients with infections; two patients were treated for a urinary tract infection, one patient with clostridium difficile, one patient treated for an upper respiratory infection, and one patient treated for acute bronchitis.</p> <p>B. The report dated August 2013 evidenced three patients with infections, one listed as sepsis, one with a chest wall infection, and one with a urinary</p>				

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	<p>tract infection.</p> <p>C. The report dated September 2013 evidenced one patient was treated for a upper respiratory infection, three for urinary tract infections, one wound infection, and one patient, # 9, listed as "massive infection ... treated with IV ATB [antibiotics]."</p> <p>D. The report dated October 2013 evidenced two patients were treated for a urinary infection.</p> <p>E. The report dated November 2013 evidenced patient 5 was treated for a sinus infection and a trachea infection, patient 1 was treated for a wound infection and another patient was treated for an infection of the ankle (the log is not specific to the infection).</p> <p>F. The report dated December 2013 included 9 patients with infections, four patients were treated for a urinary tract infection, one of which was patient 1, one patient with a wound infection, one patient was listed as sepsis, one respiratory infection, and one of the nine was patient 3 with cellulitis of the foot.</p> <p>8. During a home visit on 12/31/13 at 12:45 PM, employee B, a registered nurse, failed to demonstrate and observe</p>						

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	<p>standard universal precautions during the provision of care with patient 3 as follows:</p> <p>A. The employee carried into the home 2 bags, one black cloth like bag that resembled a purse and one plastic disposable bag, and one clipboard which were placed on the floor without a barrier beside the patient's recliner. She failed to complete hand hygiene after entering the home and before rendering any care. The black cloth bag contained a blood pressure cuff, stethoscope, and a standard blue handled utility home scissors that were co-mingled and without barriers between the items or between the items and the inside lining of the bag. The second bag was a plastic grocery bag with individually wrapped gauze and syringes and other wrapped supplies.</p> <p>B. The employee withdrew the blood pressure cuff and a stethoscope from the black bag and placed the cuff on the patient's right wrist. After assessing the patient's blood pressure, she returned the cuff to the cloth bag among the other equipment and did not decontaminate or maintain separate from the other supplies. She then used her stethoscope and placed over clothing on the patients back and chest. Following</p>						

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	<p>assessment, she returned the stethoscope to the black bag without decontaminating or maintaining separately from the other supplies.</p> <p>C. Then employee donned a pair of blue gloves and obtained the scissors from the black bag, sat on the floor and began to cut the gauze dressing, and removed the dressing from the patient's right foot. Once the dressing was removed, she placed the dressing and the scissors on the floor to her right and then brushed her hair from her face three times with the same gloved hands. She then obtained a basin of water from the home; she washed and dried the patient's right foot and noted the three dark dry scabbed wounds on the patient's little toe and three dry scabbed wounds on the second toe. She then washed and dried the left foot; the skin of the left foot was intact. While wearing the same gloves she dressed the right foot with dry gauze; she had gauze left and returned it to the manufacturer's packaging placed on the floor with the soiled dressing, then applied the patient's footwear. While continuing to wear the same gloves, she picked up the soiled dressing from the floor, the remainder of the unused gauze, and the blue handled scissors. While holding all of these items, she placed the scissors into the</p>				

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	<p>black bag without decontamination, the remainder of the dressing she placed with the patient's supplies, and the soiled dressing she disposed of in the trash. Then she removed her gloves; she did not complete hand hygiene and brushed her hair from her face.</p> <p>D. Following the dressing change employee B prepared to administer a vitamin B 12 injection and obtain a blood specimen. She placed a chair beside the patient and sat down and completed hand hygiene. She removed a single dose vial of vitamin B 12 from a plastic Ziploc style bag which contained a prescription label. She removed the manufacturer's seal from the top of the vial exposing the rubber septum, then placed the vial on the fabric arm rest of the patient's recliner. There was no barrier on the arm rest. The patient noted the vial and picked it up and held it. The employee removed a syringe from its manufacturer's sealed package, took the vial from the patient's hand, and again placed the vial in the same location on the arm rest. She then removed the sleeve cover from needle and attempted to puncture the rubber septum; she had not cleansed the top of the vial once the patient had handled the vial. The tip of the needle missed the rubber septum and struck the metal top</p>				

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	<p>surrounding the septum, she attempted again and punctured through the rubber septum of the vial and withdrew the contents. She then placed the cap of the needle on the same arm rest of the patient's recliner without a barrier and inserted the needle back into the cap to cover the needle and the syringe that remained on the arm rest capped. She then donned gloves, opened a alcohol wipe, chose the site for the injection, wiped the area with one wipe from north to south direction, removed the cap from the syringe, and administered the vitamin B 12 to the patient in the right upper extremity.</p> <p>E. She then brushed her hair away from her face with both hands as she continued to wear the same gloves. Her clipboard was on the floor was then moved to her lap. She then retrieved from her black bag on the floor a Ziploc style bag which contained supplies for collecting a blood sample. She emptied the contents from the bag onto her clipboard. She decided which supplies she needed and returned the extra back to the plastic bag and placed it in the black bag. With her right gloved hand, she brushed her hair away from her face, applied the tourniquet to the patient's right arm which was laying on the fabric covered arm rest without a barrier,</p>				

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	<p>opened an alcohol wipe and wiped the skin at the right antecubital area once in a downward motion, and then placed the needle into a vein and began to fill three laboratory tubes with blood. After collecting the blood samples and still wearing the same gloves, she pulled a cell phone from her left pocket, looked at the face, returned it to her pocket, wrote on the labels of the blood samples, returned her pen to her pocket, and secured the samples in a Ziploc style bag. She then removed her gloves; no hand hygiene was completed. She collected and placed trash in a receptacle and left the home without completing hand hygiene and holding the Ziploc bag containing the blood samples.</p> <p>F. An interview was conducted with the employee following the home visit; she indicated that the bag she was carrying was used to carry her supplies for work and indicated she did not have anything to use as a barrier with her. She indicated she would bring a barrier to the home and use if the home was dirty. She indicated she did have alcohol wipes to clean her supplies and that she would clean them before her next visit.</p> <p>G. On 1/8/14 at 11:37 AM, employee B indicated the agency did not</p>				

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	<p>have a specific policy(s) and procedure(s) regarding infection control practices the staff were to observe and practice while providing services in the home. She indicated the agency staff were to follow the infection control guidelines per the Centers for Disease Control and she did observe for breaches of infection control procedures in the home during supervisory visits. There was no documentation to support the agency assessed or monitored for infection control nor was there periodically peer to peer review or observation or refresher labs for the agency staff.</p> <p>H. On 1/8/14 at 12 PM, employee N indicated the agency did not have a written policy or procedure for how the staff were to maintain infection control during the provision of care in the patient's home; she indicated she hired professionals.</p>				

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N000484	<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 review and interview, the agency failed to ensure all personnel furnishing services documented the coordination of care while services was being provided for 2 of 11 records reviewed. (# 9 and 10). This had the potential to affect all patients who received services with the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 9, SOC (start of care) 9/26/13, evidenced the patient was receiving nursing, home health aide, and physical and occupational therapy services. The clinical record failed to evidenced documentation of coordination of care among the staff. 2. Clinical record # 10, SOC 6/3/13, evidenced the patient was receiving nursing, home health aide, and occupational therapy services. The clinical record failed to evidenced documentation of coordination of care 	N000484	It is the intent of PHI to ensure all personnel furnishing patient services document the Coordination of Care while services are being provided. The therapists will be requested to either attend the weekly Case Conference meeting or submit a Case Conference form with an update on each patient on their service for coordination of care for review weekly. The Case Managers, Field Nurses, and Support Staff will document exchange of information from other staff members on a Communication Sheet reviewed at the weekly meeting to document coordination of care. The PCC or designee will monitor for weekly therapy input and the use of Communication Sheets during the Case Conference Meetings.	02/08/2014			

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	<p>among the staff.</p> <p>Employee B indicated during an interview on 12/31/13 at 4:00 p.m., that she should have documented coordination of care between nursing staff and therapy staff.</p> <p>3. A policy titled "Client Plan of Care" dated 6/18/13, indicated the purpose was "To ensure continuity between disciplines in developing and implementing the Plan of Care ... When more than one service is involved, the Plan of Care will reflect cooperative care planning ..."</p> <p>4. A policy titled "Communication Sheet" dated 6/21/11, indicated "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC ... "</p> <p>5. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated The Case Manager, under the guidance of physicians orders, will be the overall</p>				

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N000486	<p>coordinator of home health services for the client. This includes consultation and collaboration between all professional staff who are seeing the same client, supervising other nursing staff, and making appropriate referrals as deemed necessary. All other professional staff are obliged to maintain liaison with the Case Manager. Communications between professional staff and Case manager regarding an individual client shall be documented in administrative note or on communication form ... "</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record review and interview, the agency failed to ensure the agency coordinated care with a discharging hospital prior to admission (# 2) for 1 of 2 admissions reviewed and the agency coordinated care upon a patient discharge to hospice services (# 10) for 1 of 2 records reviewed for discharges. This had the potential to</p>	N000486	<p>It is the intent of PHI to ensure our agency coordinates its services with other health or social services providers serving the patient. A policy and procedure entitled "Acquisition of Orders Prior to Admission" has been written. The Patient Care Coordinator (PCC) and Case Managers (CM) will share responsibility in obtaining all appropriate admission information. All CMs and Field</p>	02/08/2014

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	<p>affect all patients who received services with the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 2, SOC (start of care) 12/30/13, did not evidence coordination of care with a discharging hospital prior to the agency's initial evaluation and admission.</p> <p>Employee A, (Director of Nursing), was interviewed on 1/3/14 at 8:30 a.m. Employee A indicated the patient was initially supposed to have been admitted on 12/22/13, but discharge from the hospital had been put on hold. Employee A indicated the agency was not aware of the patient's discharge on 12/28/13 until staff returned to the office on Monday. Employee A indicated the agency was having difficulty obtaining paperwork from the discharging hospital. Employee A was requested to contact the hospital again for paperwork.</p> <p>2. Clinical record # 10, SOC 6/3/13, failed to evidenced coordination with a hospice upon the patient discharge to the admitting hospice company.</p> <p>Employee B was interviewed on 12/31/13 at 4:00 p.m. Employee B indicated she did not contact the hospice</p>		<p>Nurses will be in-serviced to reinforce appropriate admission information required and the necessity of coordination with a hospice upon patient discharge to the admitting hospice company. The Medical Records Clerk (MRC) will monitor the admission charts for the presence of the information outlined on the Admission Checklist. Any missing information will be reported to the PCC for immediate follow up. The MRC will report the monitoring results monthly at the QI Meeting.</p>				

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N000504	<p>company upon discharge.</p> <p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the patient was advised in advance of care of the type and frequency of services to be provided for 5 of 5 records reviewed which were admitted for services within the 60 days prior to the survey with the potential to affect all patients of the agency. (patients 2, 3, 5, 7 and 8)</p> <p>Findings include:</p> <p>1. The policy titled "Admission Criteria" number 6.2 dated 3/11/13 states, "Admission Criteria ... The client / caregiver accept the policy for periodic evaluations, which may indicate a change in level of care, frequency of</p>	N000504	<p>1.As of 2/5/14 - The "Estimated Visit Frequency and Cost of Care"form has been revised to "Visit Frequency and Cost of Care". A policy and procedure will be revised to reflect the new form title and the process for documenting the provision of care to be furnished to each patient at the start of care visit. In-services will be provided for all Case Managers, Field Nurses and support staff concerning the purpose and procedure for use of the Visit Frequency and Cost of Care form. A Visit Frequency and Cost of Care form will be completed by the Director of Nursing or designee for each patient currently on service. The Case Managers and Field Nurses will deliver these forms to the current patients on service for written and verbal explanation of</p>	02/08/2014
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	<p>visits."</p> <p>2. Clinical record # 3, start of care 11/19/13, failed to evidence the patient or legal representative was informed of the potential frequency and duration of the skilled nurse and physical and occupational therapy visits and the frequency of the aides visits to be provided.</p> <p>3. Clinical record # 5, start of care 11/26/13, failed to evidence the patient or legal representative was informed of the potential frequency and duration of the skilled nurse visits to be provided.</p> <p>4. Clinical record # 7, start of care 12/12/13, failed to evidence the patient or legal representative was informed of the potential frequency and duration of the skilled nurse and physical and occupational therapy visits and the frequency of the aides visits to be provided.</p> <p>5. Clinical record # 8, start of care 11/5/13, failed to evidence the patient or legal representative was informed of the potential frequency and duration of the aide visits to be provided.</p> <p>6. On 1/8/14 at 12 PM, employee B indicated the plan developed with the</p>		<p>frequency of visits. 2. The Visit Frequency and Cost of Care form will be given to the Case Managers with the referral forms by the Director of Nursing when an initial assessment is assigned to the Case Manager. 3.The Medical Records Clerk will check each admission chart for the presence of the signed Visit Frequency and Cost of Care form and refer any non-compliance to the Director of Nursing for follow up. The Director of Nursing or designee will audit all current patient charts for the presence of a Visit Frequency and Cost of Care form.The Director of Nursing will be responsible for ensuring ongoing compliance with this regulation.</p>		

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N000522	<p>patient and caregiver should be documented and thought it was on the admission documents.</p> <p>7. During an observation of a home visit on 12/30/13 from 3:00 p.m. to 4:30 p.m., Employee B did not inform the patient 2 in advance about the care to be furnished and the frequency of the visits.</p> <p>Employee A (Director of Nursing) was interviewed on 12/31/13 at 4:00 p.m. Employee A indicated Employee B should have informed the patient about the care to be furnished.</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:</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure treatments and visits were made as ordered and only as ordered for 4 of 11 clinical records reviewed. (# 1, 2, 9, and 10)</p> <p>Finding included:</p>	N000522	<p>1.The following standards will be reviewed with the clinical staff. a) The nurse will obtain orders from a physician for any changes in wound care treatment dressings.b) The nurse will notify any other shared provider of the physician's approval for any changes in frequency of visits.c) The RN will make supervisory visits as per regulations.d) The RN will update the Plan of Care</p>	02/08/2014			

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	<p>1. Clinical record # 1, SOC (start of care) 03/18/13, included a plan of care for the certification periods 07/16/13 to 09/13/13 and 09/14/13 to 11/12/13 with orders for wound care treatment of Prisma with Mepilex Border to the coccyx wound.</p> <p>a. Skilled nursing note dated 09/30/13 evidenced the Adhesive Restore was used on the coccyx wound.</p> <p>b. Skilled nursing note dated 10/24/13 evidenced "Repara" as the treatment used on the coccyx wound.</p> <p>c. Skilled nursing note dated 11/13/13 evidenced "Duoderm" as the treatment used on the coccyx wound.</p> <p>d. Employee A was interviewed on 12/31/13 at 3:00 p.m.. Employee A was not able to identify if the Prisma, Adhesive Restore, or Repara were equivalent treatment dressings. Employee A indicated the nurse should have obtained orders from the physician for changes in the wound care treatment dressings.</p> <p>2. During an initial / admission home visit with Patient # 2 on 12/30/13 from 3:00 p.m. to 4:30 p.m., Employee B began a head to toe assessment and</p>		<p>and incorporate in the chart within 5 days of any change in services. e) The Case Manager will obtain start of care orders after the patient consents to home health services.2. Both Case Managers have been counseled and an Employee Conference Record placed in their personnel files. The Case Managers will monitor a patient care visit for each of the Field Nurses documenting the compliance of the visit with the patient's Plan of Care. The Case Managers will monitor each other during a patient care visit and document that care is being delivered per the Plan of Care. A summary of the visit observation will be documented on a Communication Sheet and will be shared with the Director of Nursing for any follow up needed. The Director of Nursing will review all charts for changes in services as identified by review of verbal orders and monitor for 5 day care plan update. The Medical Record Clerk will track supervisory visits and inform Director of Nursing when a problem is identified. The Director of Nursing or designee will audit all admission charts for documentation of physician orders prior to treatment. The Director of Nursing will be responsible for ensuring ongoing compliance with this rules.</p>		

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	<p>assisted the spouse on colostomy care. Employee B did not obtain start of care orders after the patient consented to home health services.</p> <p>Employee A, (Director of Nursing) was interviewed and indicated Employee B should have had orders from the physician after the patient consented to services.</p> <p>3. Clinical record # 9, SOC 09/26/13, evidenced [Name of Infusion Company] ordered Skilled Nursing visits daily for 5 days then weekly and prn (as needed) for assessment, safety, medications, education, disease management, wound care as physician ordered, intravenous therapy as physician ordered, PICC line care per agency protocol, and labs as physician ordered for the certification period 09/26/13 to 11/24/13. The patient was also to receive aide services 0 week 1, 2 times a week for 8 weeks, 0 week 1 beginning during week of 09/26/13. Clinical record # 9 failed to evidenced daily visits were made for the first 5 days of services.</p> <p>a. Employee A (Director of Nursing), on 1/3/14 at 11:45 a.m., indicated the nursing staff should be following orders from [Name of Infusion Company]. Employee A</p>				

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	<p>indicated if there was a change in frequency of visits, the nurses would notify the [Name of Infusion Company] and physician for approval.</p> <p>b. The clinical record evidenced the first home health aide visit was made on 10/01/13. There was no evidence of a visit made week of 09/26/13.</p> <p>c. The employee record evidenced the patient was scheduled a second visit on 10/04/13. There was no supporting evidence to indicate the patient was seen on 10/04/13. Only one visit was made between 09/29/13 to 10/05/13.</p> <p>4. Clinical Record # 10, SOC 06/03/13, with physician plan of care orders 10/01/13 to 11/29/13 for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare and home health aid 1 time a week for 1 week, then 2 times a week for 8 weeks starting the week of 10/01/13.</p> <p>a. The clinical record did not evidenced that a supervisory visit of the home health aide was completed between 10/17/13 to 11/04/13 and again between 11/04/13 to 11/20/13.</p> <p>5. A policy titled "Client Plan of Care"</p>						

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	<p>dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client ... "</p> <p>6. A policy titled "Medical policies and physician's orders" dated 09/28/07, indicated "At times, the physician's orders may be changed, discontinued, or added in between 60-day renewals. If this occurs, the change of orders shall be sent to the physician for signature of approval of the change/new orders. The Field Nurse shall be responsible to see the change of orders is sent to the physician ... "</p> <p>7. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated "The Case Manager, under the guidance of physicians orders, will be the overall coordinator of home health services for the client ... supervising other nursing staff ... "</p>				

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure Plan of Care included all medications and treatments for 1 of 11 records reviewed (# 9) with the potential to affect all patients and orders for therapy services included the specific procedures and modalities to be used and the frequency and duration of services in 1 (# 8) of 4 clinical records reviewed of patients receiving therapy services and the potential to affect all</p>	N000524	<p>1. The Case Managers will include medications and treatments on the Plan of Care. 2. The Case Managers will be in-serviced on documenting medications and treatments on the Start Of Care Plan of Care and updating these as needed at re-certification time. 3. The Director of Nursing will monitor the Plan of Care for the presence of medications and treatments and follow up with the Case Managers for any non-compliance. The Director of</p>	02/08/2014			

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	<p>therapy patients.</p> <p>The findings include:</p> <p>1. Clinical record # 7, start of care 12/12/13 included a plan of care established by the physician for the certification period 12/12/13 through 2/9/14 with orders for a physical therapy (P.T.) and occupational therapy (O.T.) evaluation and treatment. The P.T. and O.T. evaluations were each completed on 12/13/13 (day 1 of the certification period). Physical therapy treatments were provided on December 17, 19, 23, and 27, 2013. Occupational treatments were provided on December 17, 18, 23, and 30, 2013. The plan of care and clinical record failed to evidence the physical therapist and the occupational therapist participated in the plan of care and obtained any written or verbal physician orders for the treatments. The record evidenced the OT wrote a treatment order on 12/18/13 which was submitted to the physician on 12/30/13. The record evidenced the PT wrote a PT treatment order on 12/18/13 which was submitted to the physician on 12/19/13.</p> <p>A. On 1/2/14 at 2 PM, employee A, a registered nurse, indicated their was no documentation to evidence a physician was consulted regarding the therapy</p>		Nursing will be responsible for ensuring ongoing compliance with this rules.				

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	<p>treatments to be provided prior to rendering of those therapy services.</p> <p>B. On 1/2/14 at 2:04 PM, employee I, an occupational therapist, indicated she does not call the physician for specific treatment orders following the assessment. She indicated she writes her treatment plan and it is submitted to the physician by someone other than herself.</p> <p>C. A policy titled "Client Plan of Care" dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client."</p> <p>2. Clinical record # 9, start of care 09/26/13, included a plan of care for the certification period 09/26/13 to 11/24/13 that failed to evidenced acetaminophen-hydrocodone (pain medication) 5-325 mg (milligrams) by mouth four times a day as needed, allopurinol (prevent uric acid build up / gout medication) 300 mg by mouth daily, aspirin 81 mg by mouth daily, captopril (antihypertensive) 12.5 mg by mouth daily, citalopram (antidepressant) 20 mg by mouth daily, divalproex</p>						

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	sodium (mood stabilizer) 125 mg by mouth daily, docusate (stool softner) 100 mg by mouth daily as needed, esomeprazole (stomach reflux prevention) 20 mg by mouth daily, furosemide (diuretic) 20 mg by mouth daily, gas-x (bloating) extra strength 125 mg by mouth daily as needed, lorazepam (antianxiety) 0.5 mg by mouth twice a day as needed, namenda (dementia/Alzheimer) 10 mg by mouth twice a day, polyethylene glycol (stool softners) 3350 17 gm (grams) by mouth daily as needed, pradaxa (blood thinner) 150 mg by mouth twice a day, ProAir HFA 1 puff inhaler (lung disease) four times a day as needed, trazodone (sleep) 100 mg by mouth daily at bedtime, and tylenol 650 mg by mouth every four hours as needed. The plan of care failed to evidence flow rate of Intravenous Total Parental Nutrition, treatment instructions for fistula care, and specific labs ordered for monitoring of the TPN such as complete blood count with differential, complete metabolic panel, magnesium, phosphorus, and prealbumin every Monday, basic metabolic profile and prealbumin on Thursdays, and Triglycerides and lipids monthly. The plan of care failed to evidenced the responsible medical staff to be notified of the lab results.			

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N000532	<p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on clinical record review, the agency failed to ensure the Physician was notified of a patient's deteriorating condition for 1 of 11 records reviewed (# 10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical Record # 10, start of care 06/03/13, included a plan of care for the certification period 10/01/13 to 11/29/13 with orders for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare. 2. A skilled nursing visit note dated 10/03/13, evidenced the patient was not eating much due to fatigue and chewing and swallowing was not easy. The spouse was encouraged to offer softer foods. The note evidenced the patient had lost 5 more pounds. The note stated, "No one contacted as a result of 	N000532	The Case Managers, Field Nurses, and therapists will be in-serviced on the need to alert the physician to any changes in a patient's condition. The therapists will contact the Case Managers for any physician contact made or needed. The Case Managers and Field Nurses will complete a Communication Sheet that a physicians contact was made for a change in condition. The Quality Improvement RN or designee will monitor these Communication Sheets to audit for medical record documentation. The Director of Nursing will be responsible for ensuring ongoing compliance with this rule.	02/08/2014			

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N000537	<p>this visit ... "</p> <p>3. A skilled nursing visit note dated 11/4/13, evidenced the patient diet consisted of high protein, calorie dense diet. The patient had lost significant weight. The patient was started on Remeron 7.5 mg (milligram) at bedtime to stimulate appetite. The note evidenced the patient had significant weight loss. The patient was unable to stand on the scale, but the dentures, eye glasses, and clothing were now too large. The note evidenced "no one contacted as a result of this visit ... "</p> <p>4. A Communication Sheet dated 11/21/13, evidenced a phone conversation between the patient's spouse and the case manager. The note indicated the spouse canceled the home health aide visit and indicated "[name of patient] is really going downhill quickly, much worse since Sunday." The spouse and family were considering hospice.</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and policy review and interview, the agency failed to ensure treatments and visits were</p>	N000537	<p>1.The following standards will be reviewed with the clinical staff by . a) The nurse will obtain orders from a physician for any changes</p>	02/08/2014	

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	<p>made as ordered and only as ordered for 4 of 11 clinical records reviewed. (# 1, 2, 9, and 10)</p> <p>Finding included:</p> <p>1. Clinical record # 1, SOC (start of care) 03/18/13, included a plan of care for the certification periods 07/16/13 to 09/13/13 and 09/14/13 to 11/12/13 with orders for wound care treatment of Prisma with Mepilex Border to the coccyx wound.</p> <p>a. Skilled nursing note dated 09/30/13 evidenced the Adhesive Restore was used on the coccyx wound.</p> <p>b. Skilled nursing note dated 10/24/13 evidenced "Repara" as the treatment used on the coccyx wound.</p> <p>c. Skilled nursing note dated 11/13/13 evidenced "Duoderm" as the treatment used on the coccyx wound.</p> <p>d. Employee A was interviewed on 12/31/13 at 3:00 p.m.. Employee A was not able to identify if the Prisma, Adhesive Restore, or Repara were equivalent treatment dressings. Employee A indicated the nurse should have obtained orders from the physician for changes in the wound care treatment</p>		<p>in wound care treatment dressings.b) The nurse will notify any other shared provider of the physician's approval for any changes in frequency of visits.c) The RN will make supervisory visits as per regulations.d) The RN will update the Plan of Care and incorporate in the chart within 5 days of any change in services. e) The Case Manager will obtain start of care orders after the patient consents to home health services.2. Both Case Managers have been counseled and an Employee Conference Record placed in their personnel files. The Case Managers will monitor a patient care visit for each of the Field Nurses documenting the compliance of the visit with the patient's Plan of Care.The Case Managers will monitor each other during a patient care visit and document that care is being delivered per the Plan of Care. A summary of the visit observation will be documented on a Communication Sheet and will be shared with the Director of Nursing for any follow up needed.The Director of Nursing will review all charts for changes in services as identified by review of verbal orders and monitor for 5 day care plan update. The Medical Record Clerk will track supervisory visits and inform Director of Nursing when a problem is identified. The Director of Nursing or designee will audit all admission charts for</p>		

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	<p>dressings.</p> <p>2. During an initial / admission home visit with Patient # 2 on 12/30/13 from 3:00 p.m. to 4:30 p.m., Employee B began a head to toe assessment and assisted the spouse on colostomy care. Employee B did not obtain start of care orders after the patient consented to home health services.</p> <p>Employee A, (Director of Nursing) was interviewed and indicated Employee B should have had orders from the physician after the patient consented to services.</p> <p>3. Clinical record # 9, SOC 09/26/13, evidenced [Name of Infusion Company] ordered Skilled Nursing visits daily for 5 days then weekly and prn (as needed) for assessment, safety, medications, education, disease management, wound care as physician ordered, intravenous therapy as physician ordered, PICC line care per agency protocol, and labs as physician ordered for the certification period 09/26/13 to 11/24/13. The patient was also to receive aide services 0 week 1, 2 times a week for 8 weeks, 0 week 1 beginning during week of 09/26/13. Clinical record # 9 failed to evidenced daily visits were made for the first 5 days of services.</p>		documentation of physician orders prior to treatment. The Director of Nursing will be responsible for ensuring ongoing compliance with these rules.		

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	<p>Employee A (Director of Nursing), on 1/3/14 at 11:45 a.m., indicated the nursing staff should be following orders from [Name of Infusion Company]. Employee A indicated if there was a change in frequency of visits, the nurses would notify the [Name of Infusion Company] and physician for approval.</p> <p>4. Clinical Record # 10, SOC 06/03/13, with physician plan of care orders 10/01/13 to 11/29/13 for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare and home health aid 1 time a week for 1 week, then 2 times a week for 8 weeks starting the week of 10/01/13.</p> <p>a. The clinical record did not evidenced that a supervisory visit of the home health aide was completed between 10/17/13 to 11/04/13 and again between 11/04/13 to 11/20/13.</p> <p>5. A policy titled "Client Plan of Care" dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client ... "</p>						

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N000541	<p>6. A policy titled "Medical policies and physician's orders" dated 09/28/07, indicated "At times, the physician's orders may be changed, discontinued, or added in between 60-day renewals. If this occurs, the change of orders shall be sent to the physician for signature of approval of the change/new orders. The Field Nurse shall be responsible to see the change of orders is sent to the physician ... "</p> <p>7. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated "The Case Manager, under the guidance of physicians orders, will be the overall coordinator of home health services for the client ... supervising other nursing staff ... "</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. Based on clinical record review and interview, the agency failed to ensure the registered nurse included the patients weight in the assessment and completed a total assessment of the patient's</p>	N000541	The Case Managers and Field Nurses will be in-serviced on their responsibility to re-evaluate the patient's nursing needs with emphasis on conducting thorough skin assessments and weight	02/08/2014			

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	<p>wounds for 2 of 10 clinical records reviewed that received skilled nursing services (# 3 and 10). This had the potential to affect all patients who received skilled nursing services with the agency.</p> <p>Findings include:</p> <p>1. Clinical Record # 10, start of care 06/03/13, included a plan of care for the certification period with orders for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare.</p> <p>a. A soc comprehensive assessment dated 06/03/13, indicated the patient had excessive weight loss, poor appetite and a 10 pound weight loss in the previous six months without trying. No weight was obtained or ordered at the time of admission.</p> <p>b. A recertification comprehensive assessment dated 08/01/13, indicated the patient had excessive weight loss, poor appetite and a 10 pound weight loss in the previous six months. No weight was obtained or ordered at the time of recertification.</p> <p>c. A skilled nursing visit note dated</p>		<p>monitoring. The Director of Nursing or designee will monitor all verbal orders and Plans of Care for documentation of patient skin or weight issues and audit the medical record for appropriate documentation. Any non-compliance will be addressed with the Case Managers and/or Field Nurses. The Director of Nursing will be responsible for ensuring ongoing compliance with this rule.</p>				

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	<p>09/09/13, indicated the patient only tolerated small amounts of food. The spouse was educated on the patient's need for protein and exercise. The case manager was notified of the changes. No weight was obtained as a nursing measure.</p> <p>d. A skilled nursing visit note dated 10/03/13, evidenced the patient was not eating much due to fatigue and chewing and swallowing was not easy. The spouse was encouraged to offer softer foods. The note evidenced the Patient had lost 5 more pounds. No weight was obtained as a nursing measure.</p> <p>e. A skilled nursing visit note dated 11/04/13, evidenced the patient diet consist of high protein, calorie dense diet. The patient had lost significant weight. The patient was started on Remeron 7.5 mg (milligram) at bedtime to stimulate appetite. The note evidenced the patient had significant weight loss, unable to stand on the scale, dentures, eye glasses and clothing were too large.</p> <p>f. Employee B was interviewed on 12/31/13 at 4:00 p.m. Employee B indicated she did not obtain a weight for the patient.</p>						

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	<p>2. Clinical record # 3, start of care 11/14/13, diagnosis chronic renal failure and Diabetes mellitus, included a plan of care for the certification period 11/14/13 through 1/13/14 that contained orders for skilled nursing once a week for eight weeks and a home health aide twice a week. The record evidenced the aide reported blisters on the patient's feet on 12/5/13.</p> <p>A. The skilled nurse visit note dated 12/6/13 evidenced documentation of a skin assessment which included on the right foot: 1) A fluid filled blister on the top of the foot that measured 0.5 centimeters (cm) length and 3.4 cm width, 2) A blister on the lateral outer aspect that was fluid filled and measured 4.6 cm length and 3.7 cm width, 3) A black eschar blister to the lateral side of the small toe that measured 0.6 cm length and 0.4 cm width, 4) A blood blister on the bottom of the small toe that measured 1.2 cm length and 1.0 cm width, 5) A blood blister on the under side of the second toe that measured 1.0 cm length and 1.5 cm width; and 6) A crescent shaped open area on the top of the second toe measured 0.5 cm length and 0.2 cm width. Blisters on the left foot</p>				

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	<p>included one that measured 0.2 cm length and 0.4 cm width located on the tip of the fifth toe and an open blister on the top of the fourth toe that measured 0.5 cm length and 1.1 cm width. The nurse note evidenced both feet with pitting edema of +3. The attending physician was contacted and the patient was admitted to the hospital and treated for cellulitis.</p> <p>B. The patient was discharged to home on on 12/8/13. The record evidenced employee B completed a resumption of care comprehensive assessment on 12/9/13 that failed to include a skin assessment that included the status and condition of the patient's skin and the condition of all the previous blisters on the patients feet.</p> <p>C. The record evidenced a skilled nurse visit was completed by employee L on 12/10/13 and included the purpose of the visit was to assess wounds of the feet. The visit documentation evidenced a blister was intact on the right foot, outer aspect and that the nurse was awaiting physician orders for treatment and a dry dressing was applied until further orders were received. No reference to any other</p>						

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	<p>skin issue was documented within the visit note.</p> <p>D. The record evidenced the next patient visit was on 12/17/13 and completed by employee L. The documentation indicated the blister on the right lateral foot had ruptured. No reference to any other skin issue was documented within the visit note.</p> <p>E. The record evidenced the next skilled nurse visit was on 12/24/13 and completed by employee L. The documentation indicated the area where the blister on the right lateral foot had ruptured was intact and free of signs and symptoms of infection. No other reference to the patient's skin was noted on the visit note.</p> <p>F. During a home visit on 12/31/13 at 11 AM, the patient was observed with dry scarred areas on the top of the foot and one on the outer aspect of the right foot. Also three dark dry areas on the fifth toe and three dark dry areas on the second toe. Employee B indicated, when asked, the dark areas were long standing chronic areas, and stated they were "there from the beginning" and that the [caregiver</p>				

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N000542	<p>name] was providing care daily and that the nurse was not tracking these areas. The caregiver indicated the dark dry areas on the patient's feet were chronic and informed the nurse that he / she had not monitored since Thanksgiving as was not physically capable.</p> <p>H. On 1/8/14 at 11:15 AM, employee B indicated all of the patient's skin lesions and wounds should be documented and monitored.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care was revised when orders were unclear and when the patient's condition deteriorated for 2 of 11 clinical records reviewed. This had the potential to affect all patients who were receiving care from the agency. (# 1 and 10)</p>	N000542	The Case Mangers and Field Nurses will be in-serviced to emphasize the necessity of revising the Plan of Care within 5 days when unclear orders are clarified and when a patient's condition deteriorates. The Director of Nursing or designee will monitor all verbal orders and plans of care for clarification of orders and timely care plan	02/08/2014	

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	<p>Findings include:</p> <p>1. Clinical record # 1, SOC (start of care) 03/18/13, included a plan of care for the certification periods 07/16/13 to 09/13/13 and 09/14/13 to 11/12/13 with orders for wound care of Prisma with Mepilex Border to the coccyx wound.</p> <p>a. Skilled nursing notes dated 10/03/13, 10/15/13, and 10/17/13 evidenced "Adhesive Restore" as the treatment used on the coccyx wound.</p> <p>b. Skilled nursing note dated 10/24/13 evidenced "Repara" as the treatment used on the coccyx wound.</p> <p>c. Skilled nursing note dated 11/13/13 evidenced "Duoderm" as the treatment used on the coccyx wound.</p> <p>d. Employee A was interviewed on 12/31/13 at 3:00 p.m.. Employee A was not able to identify if the Prisma, Adhesive Restore, or Repara was equivalent treatment dressings. Employee A indicated the nurse should have obtained orders from the physician for changes in the wound care treatment dressings.</p> <p>2. Clinical Record # 10, SOC 06/03/13,</p>		<p>alterations. Any non-compliance will be addressed with the Case Managers and/or Field Nurses. The Director of Nursing will be responsible for ensuring ongoing compliance with this rule.</p>				

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	<p>included a plan of care for the certification period 10/1/13 to 11/29/13 with orders for skilled nursing 1 time a month for 2 months and 3 prn (as needed) supervisory and/or recert visits per Medicare.</p> <p>a. A skilled nursing visit note dated 10/03/13 evidenced the patient was not eating much due to fatigue and chewing and swallowing was not easy. The spouse was encouraged to offer softer foods. The note evidenced the Patient had lost 5 more pounds and the neurologist suggested a feeding tube for the patient. The note evidenced "no one contacted as a result of this visit ... " Documentation failed to evidence the nurse considered revisions to the care plan.</p> <p>b. A skilled nursing visit note dated 11/04/13 evidenced the patient diet consist of high protein, calorie dense diet. The patient had lost significant weight. The patient was started on Remeron 7.5 mg (milligram) at bedtime to stimulate appetite. The note evidenced the patient had significant weight loss. The patient was unable to stand on the scale, but the dentures, eye glasses and clothing were now too large. The note evidenced "no one contacted as a result of this visit ... " Documentation</p>						

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N000545	<p>failed to evidence the nurse considered revisions to the care plan.</p> <p>3. A policy titled "Client Plan of Care" dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client ... "</p> <p>4. A policy titled "Medical policies and physician's orders" dated 09/28/07, indicated "At times, the physician's orders may be changed, discontinued, or added in between 60-day renewals. If this occurs, the change of orders shall be sent to the physician for signature of approval of the change/new orders. The Field Nurse shall be responsible to see the change of orders is sent to the physician ... "</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record and policy review review and interview, the agency</p>	N000545	It is the intent of PHI to ensure coordination of care. See N 484,	02/08/2014			

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	<p>failed to ensure the agency coordinated care with a discharging hospital prior to admission (# 2) for 1 of 2 admissions reviewed, all personnel furnishing services coordinated care effectively while services were being provided for 2 of 11 records reviewed (# 9 and 10) and the agency coordinated care upon a patient discharge to hospice services (# 10) for 1 of 2 records reviewed for discharges. This had the potential to affect all patients who received services with the agency.</p> <p>Findings include:</p> <p>1. Clinical record # 2, SOC (start of care) 12/30/13, did not evidence coordination of care with a discharging hospital prior to the agency's initial evaluation and admission.</p> <p>Employee A, (Director of Nursing), was interviewed on 1/3/14 at 8:30 a.m. Employee A indicated the patient was initially supposed to have been admitted on 12/22/13, but discharge from the hospital had been put on hold. Employee A indicated the agency was not aware of the patient's discharge on 12/28/13 until staff returned to the office on Monday. Employee A indicated the agency was having difficulty obtaining paperwork from the discharging</p>		N486, N532.				

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	<p>hospital. Employee A was requested to contact the hospital again for paperwork.</p> <p>2. Clinical record # 9, SOC (start of care) 9/26/13, evidenced the patient was receiving nursing, home health aide, and physical and occupational therapy services. The clinical record failed to evidenced coordination of services among the disciplines.</p> <p>3. Clinical record # 10, SOC 6/3/13, evidenced the patient was receiving nursing, home health aide, and occupational therapy services. The clinical record failed to evidenced coordination of services among the disciplines.</p> <p style="padding-left: 40px;">a. Clinical record # 10 failed to evidenced coordination with a hospice upon the patient discharge to the admitting hospice company.</p> <p style="padding-left: 40px;">b. Employee B was interviewed on 12/31/13 at 4:00 p.m. Employee B indicated she did not contact the hospice company upon discharge.</p> <p>4. A policy titled "Client Plan of Care" dated 6/18/13, indicated the purpose was "To ensure continuity between disciplines in developing and implementing the Plan of Care ... When</p>						

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	<p>more than one service is involved, the Plan of Care will reflect cooperative care planning"</p> <p>5. A policy titled "Communication Sheet" dated 6/21/11, indicated "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC"</p> <p>6. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated The Case Manager, under the guidance of physicians orders, will be the overall coordinator of home health services for the client. This includes consultation and collaboration between all professional staff who are seeing the same client, supervising other nursing staff, and making appropriate referrals as deemed necessary. All other professional staff are obliged to maintain liaison with the Case Manager ... "</p>						

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N000550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on the clinical record and policy review, the agency failed to ensure the registered nurse provided care instructions for the home health aides with specific frequencies for 2 of 7 clinical records reviewed with orders for a home health aide with the potential to affect all patients who receive home health aide services. (# 9 and 10)</p> <p>The findings include:</p> <p>1. Clinical Record # 9, SOC 09/26/13, included a plan of care for the certification period 09/26/13 to 11/24/13 with physician's orders for home health aide services 0 week 1, 2 times a week for 8 weeks, 0 week 1 beginning during week of 09/26/13. The Home Health Aide care plan revised on 09/26/13, evidenced hygiene (bath, perineal, skin care, oral care, shampoo, shave and dress assist), home management (clean bathroom after patient care), elimination (assist to bedside commode / toilet and empty ostomy bag) to be completed</p>	N000550	<p>It is the intent of PHI to ensure the RN delegates duties and tasks to LPN's and other individuals as appropriate. The Case Managers will document the frequency of visits as ordered or note per request of patient/caregiver per authorization on the hygiene screen under "other" of the home health aide assignment sheet in the clinical software program. The Home Health Aide Scheduler (HHAS) will monitor each aide assignment sheet she receives from the case managers and inform the case managers if frequency is not noted and return for correction. The HHAS will inform the PCC of any non-compliance for follow up with the case managers.</p>	02/08/2014			

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	<p>"prn" (as needed). There were no specific frequencies identified that the aide was to provide the care.</p> <p>2. Clinical record # 10, SOC 06/03/13, included a plan of care for the certification period 10/01/13 to 11/29/13 with physician's orders for home health aide services 1 time a week for week and 1 and 2 times a week for 8 weeks per Medicare with skilled nursing supervision per Medicare guidelines beginning the week of 10/01/13. The Home Health Aide Care Plan indicated hygiene prn with warm soaks and gentle massage of hands, ambulate only with assistance of a walker prn, ROM (range of motion) exercises prn to the arms and legs, and follow exercise plan. The comment / note section indicated hand weights as patient tolerates, 5 minutes with exercise bike as patient tolerates. The care plan evidenced to encourage high calorie snacks, clean up kitchen after meal preparation and clean bathroom after patient care prn. There were no specific frequencies identified that the aide was to provide the care.</p> <p>3. A policy titled "Home Health Aide Services) dated 06/05/13, indicated "Home health aide services will be provided to clients in a safe manner ... The home health aide's primary function</p>						

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N000565	<p>under Medicare is to provide personal care ...Assistance with walking simple exercise program approved by nurse, or therapist .."</p> <p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); Based on clinical record and policy review and interview, the agency failed to ensure the physical and occupational therapist participated in the development of the patient's written plan of care by obtaining specific orders for therapy treatments in 1 (# 8) of 4 clinical records reviewed of patients receiving therapy services and the potential to affect all therapy patients.</p> <p>The findings include:</p> <p>1. Clinical record # 7, start of care 12/12/13 included a plan of care established by the physician for the certification period 12/12/13 through 2/9/14 with orders for a physical therapy (P.T.) and occupational therapy (O.T.) evaluation and treatment. The P.T. and O.T. evaluations were each completed on 12/13/13 (day 1 of the certification period). Physical therapy treatments were provided on December 17, 19, 23,</p>	N000565	The Physical Therapist and Occupational Therapist will be in-serviced on the regulations requiring participation in the developing of the Plan of Care by obtaining specific orders for therapy treatments prior to treating patients. The Quality Improvement RN will audit all physical therapy and occupational therapy initial evaluations for documentation of physician contact for treatment orders and incorporation into the Plan of Care. The therapist will be contacted for corrections. The Director of Nursing will be responsible for ensuring ongoing compliance with this rule.	02/08/2014			

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	<p>and 27, 2013. Occupational treatments were provided on December 17, 18, 23, and 30, 2013. The plan of care and clinical record failed to evidence the physical therapist and the occupational therapist participated in the plan of care and obtained any written or verbal physician orders for the treatments.</p> <p>On 1/2/14 at 2 PM, employee A, a registered nurse, indicated their was no documentation to evidence a physician was consulted regarding the therapy treatments to be provided prior to rendering of those therapy services.</p> <p>2. On 1/2/14 at 2:04 PM, employee I, an occupational therapist, indicated she does not call the physician for specific treatment orders following the assessment. She indicated she writes her treatment plan and it is submitted to the physician by someone other than herself.</p> <p>3. A policy titled "Client Plan of Care" dated 06/18/13, indicated "The physician will be consulted and orders obtained for all services to be provided ... The plan will be updated as appropriate and incorporated in the chart within five days of any change in services to be provided to the client."</p>						

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N000567	<p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on clinical record review, policy review, and interview, the agency failed to ensure qualified therapists advised and consulted with agency personnel for 2 of 4 clinical records reviewed that received therapy services (#9 and 10). This had the potential to affect all patient who were receiving therapy services.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Clinical record # 9, SOC (start of care) 09/26/13, evidenced the patient was receiving skilled nursing, home health aide, and physical and occupational therapy services. The clinical record failed to evidence communication between the disciplines. Clinical record # 10, SOC 06/03/13, evidenced the patient was receiving skilled nursing, home health aide, and occupational therapy services. Occupational therapy missed visit notes dated 10/19/13 and 10/20/13 did not evidenced communication between the occupational therapist and the case 	N000567	The Physical Therapist and Occupational Therapist will be in-serviced onthe necessity of advising and consulting with agency personnel. The Physical Therapist and Occupational Therapist will provide weekly written updates for Case Managers review. Any therapy contacts with the Case Managers will be documented on a Communication Sheet and forwarded to the Director of Nursing or designee for review. The Case Managers will contact the therapists for any non-compliance.The Directorof Nursing will be responsible for ensuring ongoing compliance with this regulation.	02/08/2014

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	<p>manager. The missed visit notes evidenced the patient did not feel well.</p> <p>3. A policy titled "Therapy Policies" dated 10/06, indicated "The therapist shall consult and collaborate with the professional nurse who is case manager of the physician's Plan of Care.</p> <p>4. A policy titled "Communication Sheet" dated 06/21/11, indicated "A Communication Sheet will be utilized to inform other disciplines and personnel of any problems or concerns ... Purpose: to facilitate good communication between disciplines and support staff ... The Sheet will be given to the case manager or Patient Care Coordinator (PCC) for follow up and shared with all staff at the case conference meeting weekly by the PCC ... "</p> <p>5. A policy titled "Nursing Services and Procedures" dated 07/13/12, indicated The Case Manager, under the guidance of physicians orders, will be the overall coordinator of home health services for the client. This includes consultation and collaboration between all professional staff who are seeing the same client, supervising other nursing staff, and making appropriate referrals as deemed necessary. All other professional staff are obliged to maintain</p>						

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N000596	<p>liaison with the Case Manager. Communications between professional staff and Case manager regarding an individual client shall be documented in administrative note or on communication form ... "</p> <p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file review, policy review, and interviews, the agency failed to ensure the home health aides successfully completed a competency evaluation program before the aide provided care for 3 of 6 aide files reviewed with the potential to affect all the patients receiving home health aide services. (C, J, and K)</p> <p>The findings include:</p> <p>1. Personnel record C, date of hire 07/30/13 and first patient contact 08/01/13, evidenced a document titled "Certified Home Health/ Hospice Aide Checklist" signed by the home health</p>	N000596	It is the intent of PHI to ensure home health aides successfully complete a competency evaluation program prior to providing patient care. For the two year period of January 17, 2014 through January 17, 2016 an outside contracted RN who has a minimum of two years of nursing experience with at least one year of home health care experience will be recruited to provide the Competency Evaluation Program and the Home Health Aide In-service Training Program for PHI per State and Federal Regulations. The PCC or designee will monitor the Home Health Aide Training and In-service Program for compliance.	02/08/2014			

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	<p>aide on 08/02/13 and by the Administrator (Registered Nurse) on 08/01/13, 08/02/13, and 08/05/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning) and fluid balance evidenced skills were met on 08/01/13 in the agency lab. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair/shampoo) evidenced skills were met on 08/02/13, hair / shampoo by bed on 08/01/13, by sink on 08/02/13, and bathtub on 08/05/13 did not evidenced location but indicated "no problems". The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>c. Vital signs was met on 08/01/13 but indicated "lab only our aides do not take vitals"</p> <p>d. Employee A (Director of Nursing), on 01/03/14 at 3:00 p.m., indicated the skills evaluation were done incorrectly and the task was given to a case manager.</p> <p>2. Personnel record J, date of hire 07/23/13 and first patient contact</p>						

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	<p>07/26/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 07/30/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, nail care, hair / shampoo, and prevention of skin breakdown), body functions (vital signs, and fluid balance), environmental services (linen change) evidenced the skills were met on 07/26/13. The shower, tub and sponge bath of personal care was met on 07/27/13 and re-tested on 07/30/13 [sic]. The toileting (bathroom, bedpan, urinal bedside commode, and catheter) were met on 07/26/13 and re-tested on 07/30/13 [sic]. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Interview with Employee J (Home Health Aide) on 01/03/14 at 4:00 p.m., indicated the skills evaluation and check off was completed in the agency lab and not in the patient's home.</p> <p>3. Personnel record K, date of hire 09/24/13 and first patient contact 10/03/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health</p>						

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	<p>aide and a registered nurse on 10/03/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair / shampoo, and prevention of skin breakdown), vital signs and fluid balance evidenced the skills were met on 09/24/13. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>4. A policy titled "Home Health Aide Competency Policy" dated 07/13/12, indicated "Individuals working under the job description of home health aide, must be certified and demonstrate competency prior to being independently placed in the field with clients ... The [Name of Network] Aide Checklist for Skills Demonstration with no more than one unsuccessful area, Evaluation will be administered during initial orientation before independent assignment to clients ... Additional skills required for care will be verified as competent by the referring RN, therapist or PCC (Patient Care Coordinator) prior to independent care being given."</p>						

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N000598	<p>410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.</p> <p>Based on personnel record, policy review and interview, the agency failed to ensure documentation evidenced the home health aide successfully completed a competency evaluation program before the aide provided care for 3 of 6 aide files reviewed with the potential to affect all the patients receiving home health aide services. (C, J, and K)</p> <p>The findings include:</p> <p>1. Personnel record C, date of hire 07/30/13 and first patient contact 08/01/13, evidenced a document titled "Certified Home Health/ Hospice Aide Checklist" signed by the home health aide on 08/02/13 and by the Administrator (Registered Nurse) on 08/01/13, 08/02/13, and 08/05/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning) and fluid balance evidenced skills were met on 08/01/13 in the agency lab. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p>	N000598	It is the intent of PHI to ensure documentation that evidences the home health aide successfully completed a competence program before providing patient care. See N 596	02/08/2014			

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	<p>b. Personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair/shampoo) evidenced skills were met on 08/02/13, hair / shampoo by bed on 08/01/13, by sink on 08/02/13, and bathtub on 08/05/13 did not evidenced location but indicated "no problems". The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>c. Vital signs was met on 08/01/13 but indicated "lab only our aides do not take vitals"</p> <p>d. Employee A (Director of Nursing), on 01/03/14 at 3:00 p.m., indicated the skills evaluation were done incorrectly and the task was given to a case manager.</p> <p>2. Personnel record J, date of hire 07/23/13 and first patient contact 07/26/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 07/30/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, nail care, hair / shampoo, and prevention of skin breakdown), body functions (vital signs, and fluid balance), environmental</p>						

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	<p>services (linen change) evidenced the skills were met on 07/26/13. The shower, tub and sponge bath of personal care was met on 07/27/13 and re-tested on 07/30/13 [sic]. The toileting (bathroom, bedpan, urinal bedside commode, and catheter) were met on 07/26/13 and re-tested on 07/30/13 [sic]. The form did not evidenced if the skill were met with direct care or with a pseudo-patient.</p> <p>b. Interview with Employee J (Home Health Aide) on 01/03/14 at 4:00 p.m., indicated the skills evaluation and check off was completed in the agency lab and not in the patient's home.</p> <p>3. Personnel record K, date of hire 09/24/13 and first patient contact 10/03/13, evidenced a document titled "Certified Home Health / Hospice Aide Checklist" signed by the home health aide and a registered nurse on 10/03/13.</p> <p>a. Mobility (ambulation, range of motion, transfer and positioning), personal care (oral, bed bath, bath by shower / tub / sponge, nail care, hair / shampoo, and prevention of skin breakdown), vital signs and fluid balance evidenced the skills were met on 09/24/13. The form did not evidenced if the skill were met with direct care or</p>						

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	with a pseudo-patient. 4. A policy titled "Home Health Aide Competency Policy" dated 07/13/12, indicated "Individuals working under the job description of home health aide, must be certified and demonstrate competency prior to being independently placed in the field with clients ... The [Name of Network] Aide Checklist for Skills Demonstration with no more than one unsuccessful area, Evaluation will be administered during initial orientation before independent assignment to clients ... Additional skills required for care will be verified as competent by the referring RN, therapist or PCC (Patient Care Coordinator) prior to independent care being given."				

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N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure clinical visits were documented timely and incorporated into the clinical record timely and within 10 days per agency policy in 4 of 11 (1, 5, 9, and 10) clinical records reviewed creating the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. On 12/30/13 at 9:30 AM, the director of nursing indicated during the entrance conference that the skilled nurse visit notes were to be completed by the</p>	N000608	The Case Managers will be in-serviced on the regulations for timely documentation of visit notes and OASIS completion. The "ClientClinical Record Filing System" policy and procedure will be revised and reviewed during the in-service. The Case Managers have been counseled and an Employee Conference Record placed in their personnel files. The Quality Improvement RN will monitor for timely visit note documentation and auditing the certification time points for complete and accurate documentation. Non-compliance will be referred to the Case Managers for correction. The Director of Nursing will be	02/08/2014			

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	<p>Monday following the week in which the visit was made and that admission assessments were to be completed within five days.</p> <p>2. Clinical record #5, start of care 11/26/13, included a physician's plan of care for certification period 11/26/13 to 1/24/14 and contained orders for skilled nursing services to teach the primary caregiver intravenous infusion skills using a peripherally inserted central catheter (PICC), PICC dressing changes, lab draws via the PICC and catheter care, and troubleshooting. The clinical record evidenced:</p> <p>A. Employee G conducted an assessment on 11/26/13 and infused antibiotics intravenously via the PICC. The documented evidenced the clinician did not complete the documentation and sign the assessment until 12/6/13, 10 days after the visit was completed.</p> <p>B. A skilled nurse visit note dated 11/27/13 at 4 AM evidenced employee G educated the caregiver on IV antibiotic administration via the PICC, performed catheter line care, and assessed the patient. The document evidenced the clinician did not complete the documentation and sign the assessment until 12/13/13, 16 days after</p>		responsible for ensuring ongoing compliance with this rule.		

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	<p>the visit was completed.</p> <p>C. A skilled nurse visit note dated 11/27/13 at 10 AM evidenced employee G educated the caregiver on IV antibiotic administration, observed the caregiver perform the antibiotic infusion, and assessed the patient. The document evidenced the clinician did not complete the documentation and sign the assessment until 12/13/13, 16 days after the visit was completed.</p> <p>D. A skilled nurse visit note dated 11/27/13 at 3:55 PM evidenced employee G educated the caregiver on IV antibiotic administration and assessed the patient. The document evidenced the clinician did not complete the documentation and sign the assessment until 12/13/13, 16 days after the visit was completed.</p> <p>E. A skilled nurse visit note dated 11/29/13 at 5:45 PM evidenced employee G withdrew blood sample for labs including a trough, changed the end caps and flushed both lumens with heparin and saline, and and assessed the patient. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/13/13, 14 days after the visit was completed.</p>						

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	<p>F. A skilled nurse visit note dated 12/2/13 at 12:10 PM evidenced employee G assessed the patient and infused an antibiotic intravenously and flushed the PICC with heparin and saline. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/13/13, 11 days after the visit was completed.</p> <p>G. A skilled nurse visit note dated 12/2/13 at 6:15 PM evidenced employee G assessed the patient, withdrew blood sample for labs and included an antibiotic trough, performed PICC line care, and flushed the patients PICC line with heparin and saline. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/13/13, 11 days after the visit was completed.</p> <p>H. A skilled nurse visit note dated 12/3/13 at 12 PM evidenced employee G assessed the patient. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/13/13, 10 days after the visit was completed.</p> <p>I. A skilled nurse visit note dated 12/4/13 at 12 PM evidenced employee G</p>						

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	<p>assessed the patient and performed PICC line care and flushed the patients PICC line with heparin and saline. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/23/13, 19 days after the visit was completed.</p> <p>J. A skilled nurse visit note dated 12/5/13 at 12 PM evidenced employee G assessed the patient, performed PICC line care, and flushed port with heparin and saline. The document evidenced the clinician did not complete the documentation and sign the visit note until 12/23/13, 18 days after the visit was completed.</p> <p>K. A skilled nurse visit note dated 12/7/13 at 3:10 PM failed to evidence any care was provided nor an assessment on the patient. Employee B completed and signed the visit note on 12/20/13, 13 days after the visit was completed.</p> <p>L. A skilled nurse visit note dated 12/11/13 at 2:20 PM evidenced employee G removed the PICC line and dressed the access site. Employee G completed and signed the visit note on 12/23/13, 12 days after the visit was completed.</p> <p>3. On 1/9/14 at 12 PM, employee B</p>						

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	<p>indicated the facility did not have a written policy to guide staff as to how much time should lapse between the time services are provided and how soon the staff are to document and sign their visit notes.</p> <p>4. The agency policy titled "Client Clinical Record Filing System" number 13.4 effective date 9/04 states, "Filing is kept timely. All documentation is filed within 10 working days of submission."</p> <p>5. Clinical record # 1, SOC (start of care) 03/18/13, evidenced:</p> <p>a. A nursing visit note indicated the date of visit was on 10/11/13. The note was entered into the electronic medical record on 11/01/13.</p> <p>b. A nursing visit note indicated the date of visit was on 11/04/13. The note was entered into the electronic medical record on 12/05/13.</p> <p>c. A nursing visit note indicated the date of visit was on 11/27/13. The note was entered into the electronic medical record on 12/19/13.</p> <p>d. A nursing visit note indicated the date of visit was on 12/07/13. The note</p>				

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	<p>was entered into the electronic medical record on 12/20/13.</p> <p>e. A nursing visit note indicated the date of visit was on 12/09/13. The note was entered into the electronic medical record on 12/20/13.</p> <p>6. Clinical record # 9, SOC 09/26/13, evidenced lab requisitions dated 09/30/13, 10/03/13, 10/14/13, 10/21/13, 10/24/13, and 10/31/13. There was no evidence of the laboratory results in the clinical record.</p> <p>a. A nursing visit note indicated the date of visit was on 10/07/13. The note was entered into the electronic medical record on 10/25/13.</p> <p>b. A nursing visit note indicated the date of visit was on 10/16/13. The patient was discharged on 11/04/13. The note was entered into the electronic medical record on 11/08/13.</p> <p>c. A nursing visit note indicated the date of visit was on 10/17/13. The patient was discharged on 11/04/13. The note was entered into the electronic medical record on 11/08/13.</p> <p>d. A nursing visit note indicated the date of visit was on 10/28/13. The</p>						

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	<p>patient was discharged on 11/04/13. The note was entered into the electronic medical record on 11/20/13.</p> <p>e. A nursing visit note indicated the date of visit was on 10/31/13. The patient was discharged on 11/04/13. The note was entered into the electronic medical record on 11/20/13.</p> <p>f. A nursing visit note indicated the date of visit was on 11/04/13. The patient was discharged on 11/04/13. The note was entered into the electronic medical record on 11/21/13.</p> <p>7. Clinical Record # 10, SOC 06/03/13, evidenced:</p> <p>a. A recertification oasis indicated the date of visit was on 09/30/13. There was no date of entry indicated in the signature box.</p> <p>b. A nursing visit note indicated the date of visit was on 10/03/13. The note was entered into the electronic medical record on 10/17/13.</p> <p>c. A nursing visit note indicated the date of visit was on 11/04/13. The note was entered into the electronic medical record on 11/25/13.</p>				

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	<p>d. A discharge oasis indicated the date of visit was on 11/20/13. There was no date of entry indicated in the signature box.</p> <p>8. Employee A (Director of Nursing), on 01/04/13 at 11:45 p.m., indicated the nursing computers did not generally go into the patient's home. Employee A indicated the Administrator would want the visits in the record within 7 days. Employee A indicated the lab results should had been obtained from the laboratory and placed in the chart.</p>			