

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K039	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/30/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE'S TOUCH HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220
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G000000	<p>This was a Federal home health recertification survey. This was an extended survey.</p> <p>Survey date: 07/24, 07/25, 07/28, 07/29, and 07/30/14.</p> <p>Facility: 011480</p> <p>Medicaid Vendor: 200893000</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Census: 75</p> <p>The agency is precluded from providing a home health aide training and competency program for a period of 2 years beginning 08/07/14 for being found out of compliance with the Conditions of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, Medical Supervision and 484.30 Nursing Services: 484.36.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 7, 2014</p>	G000000		

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

TITLE

(X6) DATE

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

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G000143	<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, document, and policy review, the agency failed to ensure all agency personnel furnishing services maintained liaison and communicated with outside service providers to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care for 3 of 10 records reviewed creating the potential to affect all patients who received more than one service from the agency or received services from another provider. (#4, 5, and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide to assist patient with personal care needs and ADL's (activities of daily living), to provide effective personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check pressure areas, assist</p>	G000143	<p>The Director of Nurses has inserviced all RN Case Managers regarding the requirement for all clients receiving services from another provider that a detailed care coordination must be completed. Coordination of care must include service provided with frequency and duration. Progression toward goals and schedule of caregivers. All Life's Touch Home Health care staff providing services for clients who also receive services from another provider must clock out when the other provider is in the home. A care coordination form has been developed to address all of the required elements. Timesheets are modified to allow staff to clock in and out as needed. All RN case managers have been educated on the policy "Coordination of Client Services". Client records have been audited for compliance with coordination of client services. Coordination of client services with dialysis units will include schedule and frequency of treatments, access type and who is responsible for care of access and all medications given in dialysis to be included on client's medication</p>	08/27/2014

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	<p>with ambulation, transfer to get in / out the bathroom, medication reminder, light housekeeping, and cleaning bathroom, 6 hours a day with AM/PM visits, 7 days a week.</p> <p>a. The plan of care stated that the patient was receiving nursing, physical, and occupational services with a skilled Medicare agency.</p> <p>b. A Coordination of Care form dated 07/23/14 stated an update was given to an employee of the outside agency on the client. The form failed to evidence specific details of the coordination in order to prevent overlapping of visits between a Medicare Agency and a Medicaid Agency.</p> <p>c. Employee C, a home health aide, indicated during the home visit on 07/28/14 at 10:45 AM, she does not leave the patient's home and she was in the patient's home from 9 to 5.</p> <p>2. Clinical record number 5, SOC (start of care) 02/14/14, included a plan of care established by a physician for the certification period of 06/12/14 to 08/10/14 with orders for home health aide services.</p> <p>a. A Coordination of Care form dated</p>		<p>administration record. Care coordination form developed to address all required elements. 10% of clinical records will be audited quarterly for compliance with care coordination needs. RN case managers will be provided education on coordination of client services on hire. If deficiencies are discovered on clinical record audits, the RN case manager will be provided additional education. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>04/08/14 stated "[Name of Medicare Agency] in home at time of visit - Coordinated Care" and under Dialysis "Continues to do dialysis with [Initial of center]." The Medicare agency was providing wound care and therapy services. The form failed to evidence any coordination regarding the wound care and therapy services.</p> <p>b. The plan of care stated the patient was receiving outside services with a Medicare home health agency and the patient was going to a dialysis center for treatment. A Coordination of Care form dated 06/10/14 stated, "Still Attends." The form failed to evidence any coordination with the dialysis facility.</p> <p>c. A Coordination of Care form dated 06/10/14 stated, "Rep at home at time of recert - conference in home." The form failed to evidence any coordination regarding the wound care and therapy services.</p> <p>d. The clinical record failed to evidence the agency coordinated services with the dialysis center.</p> <p>3. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to</p>				

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	<p>07/17/14 with orders for home health aide services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 4 hours daily to assist with bathing, dressing, grooming, meal prep and service, incontinence care, and transfer assist; attendant care services 6 days a week for 1 week, 7 days a week (sic), 5 days a week for 1 week up to 5 hours a daily 7 days a week to assist with meal prep and service, light housekeeping, incontinence care, and transfer assist; and homemaker services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 1 hour daily to assist with light housekeeping.</p> <p>a. A Coordination of Care communication log dated 03/18/14 stated the Medicare skilled agency performed the patient's wound treatments 3 times a week, monthly foley catheter changes, B12 injections monthly, and biweekly medication set up. Life Touch Home Health requested the Medicare agency's home health aide schedule, but the Medicare skilled agency did not have a schedule and indicated they would notify Life Touch Home Health when available. The form failed to evidence any coordination regarding the problems addressed by the Medicare agency.</p>			

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	<p>b. A Coordination of Care communication log dated 04/29/14 indicated the skilled Medicare Agency still did not have a home health aide. The clinical record failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services or any coordination regarding the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>c. A Coordination of Care communication log dated 06/09/14 indicted the skilled Medicare Agency was providing IV (intravenous) antibiotic treatment for a chronic urinary tract infection. The form failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>d. A Coordination of Care communication log dated 06/16/14 stated that the skilled Medicare Agency was to provide physical therapy services upon resumption of care and the patient was continuing to have IV antibiotics in the home. The form failed to evidence</p>			

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	<p>documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>e. Coordination of Care communication log dated 06/25/14, 07/01/14, 07/11/14, and 07/23/14 failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>4. The Director of Nursing indicated on 07/30/14 at 1:00 PM indicated she had addressed the status of issues with the other agencies, she just hadn't written it down to prove she had established coordination of services. She also indicated she was not aware that she needed to coordinated services with the dialysis center.</p> <p>5. An undated policy titled "Coordination of Client Services" stated the purpose was "To ensure appropriate, quality care is being provided to clients, To establish effective interchange,</p>			

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G000144	<p>reporting, and coordination of client care does occur, To assure that the efforts of agency personnel effectively complement one another and support the objectives outlined in the Plan of Care, to modify the plan to reflect needs or changes identified by members of the team and avoid duplication of services, to identify needs to modify the plan of care, to evaluate the adequacy of treatment and the effect of services provided, to determine the continuation of services and / or future plans of care ... "</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, document, and policy review, the agency failed to ensure all agency personnel furnishing services maintained liaison and communicated with outside service providers to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care for 3 of 10 records reviewed creating the potential to affect all patients who received more than one service from the agency or received services from another provider. (#4, 5,</p>	G000144	The Director of Nurses has inserviced all RN Case Managers regarding the requirement for all clients receiving services from another provider that a detailed care coordination must be completed. Coordination of care must include service provided with frequency and duration. Progression toward goals and schedule of caregivers. All Life's Touch Home Health care staff providing services for clients who also receive services from another provider must clock out	08/27/2014

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	<p>and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide to assist patient with personal care needs and ADL's (activities of daily living), to provide effective personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check pressure areas, assist with ambulation, transfer to get in / out the bathroom, medication reminder, light housekeeping, and cleaning bathroom, 6 hours a day with AM/PM visits, 7 days a week.</p> <p>a. The plan of care stated that the patient was receiving nursing, physical, and occupational services with a skilled Medicare agency.</p> <p>b. A Coordination of Care form dated 07/23/14 stated an update was given to an employee of the outside agency on the client. The form failed to evidence specific details of the coordination in order to prevent overlapping of visits between a Medicare Agency and a Medicaid Agency.</p>		<p>when the other provider is in the home. A care coordination form has been developed to address all of the required elements. Timesheets are modified to allow staff to clock in and out as needed. All RN case managers have been educated on the policy "Coordination of Client Services". Client records have been audited for compliance with coordination of client services. Coordination of client services with dialysis units will include schedule and frequency of treatments, access type and who is responsible for care of access and all medications given in dialysis to be included on client's medication administration record. Care coordination form developed to address all required elements. 10% of clinical records will be audited quarterly for compliance with care coordination needs. RN case managers will be provided education on coordination of client services on hire. If deficiencies are discovered on clinical record audits, the RN case manager will be provided additional education. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>c. Employee C, a home health aide, indicated during the home visit on 07/28/14 at 10:45 AM, she does not leave the patient's home and she was in the patient's home from 9 to 5.</p> <p>2. Clinical record number 5, SOC (start of care) 02/14/14, included a plan of care established by a physician for the certification period of 06/12/14 to 08/10/14 with orders for home health aide services.</p> <p>a. A Coordination of Care form dated 04/08/14 stated "[Name of Medicare Agency] in home at time of visit - Coordinated Care" and under Dialysis "Continues to do dialysis with [Initial of center]." The Medicare agency was providing wound care and therapy services. The form failed to evidence any coordination regarding the wound care and therapy services.</p> <p>b. The plan of care stated the patient was receiving outside services with a Medicare home health agency and the patient was going to a dialysis center for treatment. A Coordination of Care form dated 06/10/14 stated, "Still Attends." The form failed to evidence any coordination with the dialysis facility.</p> <p>c. A Coordination of Care form dated</p>			

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	<p>06/10/14 stated, "Rep at home at time of recert - conference in home." The form failed to evidence any coordination regarding the wound care and therapy services.</p> <p>d. The clinical record failed to evidence the agency coordinated services with the dialysis center.</p> <p>3. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for home health aide services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 4 hours daily to assist with bathing, dressing, grooming, meal prep and service, incontinence care, and transfer assist; attendant care services 6 days a week for 1 week, 7 days a week (sic), 5 days a week for 1 week up to 5 hours a daily 7 days a week to assist with meal prep and service, light housekeeping, incontinence care, and transfer assist; and homemaker services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 1 hour daily to assist with light housekeeping.</p> <p>a. A Coordination of Care communication log dated 03/18/14 stated</p>			

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	<p>the Medicare skilled agency performed the patient's wound treatments 3 times a week, monthly foley catheter changes, B12 injections monthly, and biweekly medication set up. Life Touch Home Health requested the Medicare agency's home health aide schedule, but the Medicare skilled agency did not have a schedule and indicated they would notify Life Touch Home Health when available. The form failed to evidence any coordination regarding the problems addressed by the Medicare agency.</p> <p>b. A Coordination of Care communication log dated 04/29/14 indicated the skilled Medicare Agency still did not have a home health aide. The clinical record failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services or any coordination regarding the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>c. A Coordination of Care communication log dated 06/09/14 indicted the skilled Medicare Agency was providing IV (intravenous) antibiotic treatment for a chronic urinary tract infection. The form failed to evidence documentation to indicate if the skilled</p>			

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	<p>agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>d. A Coordination of Care communication log dated 06/16/14 stated that the skilled Medicare Agency was to provide physical therapy services upon resumption of care and the patient was continuing to have IV antibiotics in the home. The form failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>e. Coordination of Care communication log dated 06/25/14, 07/01/14, 07/11/14, and 07/23/14 failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>4. The Director of Nursing indicated on</p>				

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	<p>07/30/14 at 1:00 PM indicated she had addressed the status of issues with the other agencies, she just hadn't written it down to prove she had established coordination of services. She also indicated she was not aware that she needed to coordinated services with the dialysis center.</p> <p>5. An undated policy titled "Coordination of Client Services" stated the purpose was "To ensure appropriate, quality care is being provided to clients, To establish effective interchange, reporting, and coordination of client care does occur, To assure that the efforts of agency personnel effectively complement one another and support the objectives outlined in the Plan of Care, to modify the plan to reflect needs or changes identified by members of the team and avoid duplication of services, to identify needs to modify the plan of care, to evaluate the adequacy of treatment and the effect of services provided, to determine the continuation of services and / or future plans of care ... "</p>				

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G000156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record review and interview, it was determined the agency failed to ensure visits were made as ordered on the plan of care for, oxygen settings were obtained and documented weekly, and there were orders for the care provided for 4 of 10 records reviewed creating the potential to affect all patients currently receiving services from the agency (See G 158); failed to ensure plan of care were revised and updated to include all durable medical equipment, outside services, duration of visits, specific treatment orders and medication reminders for 7 of 10 records reviewed creating the potential to affect all patients receiving services with the agency (See G 159); and failed to ensure wound treatments was administered as ordered by the physician for 1 of 10 records reviewed with wounds creating the potential to affect all 3 patients with wounds within the facility (See G 165).</p> <p>The cumulative effect of these systemic problems resulted in the agency being</p>	G000156	<p>The Director of Nurse has educated the staff on physician notification for any deviations from the plan of care, missed visits and frequency and duration of ordered services. The Director of Nurses has educated and instructed the RN case managers of the regulations and policies concerning collaboration and notification of the proposed patient care needs after completing the comprehensive assessment, documentation of all DME, supplemental services being provided, detailed care needs and instructions on plan of care, accurate frequency and duration of disciplines providing care, following all physician orders on the plan of care and concise documentation of provided care, the necessity of communicating with staff concerning changes in the plan of care. Regularly scheduled meetings with professional and administrative staff to ensure that the plan of care is being followed in regards to frequency and duration of visits. Clinical records have been audited for any deviations from the plan of care,</p>	08/27/2014

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NAME OF PROVIDER OR SUPPLIER  LIFE'S TOUCH HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220
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	found out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care, & Medical Supervision.		contact with physician of record following completion of comprehensive assessment to establish plan of care, supplemental services being provided, specific care needs and instructions to complete ordered care, accurate frequency and duration of all disciplines and accurate documentation. 10% of all clinical records will be audited quarterly for compliance with physician notification for the development of plan of care, any deviations from the plan of care-including missed visits, that frequency and/or duration changes have been documented and reported to physician. Audit process will also look at accurate treatment orders, supplemental services included on plan of care and that DME needs are noted. Records will be reviewed for compliance with following the physician ordered plan of care and supporting documentation. New hire orientation will include education on accurate development of plan of care, discussing with the client any supplemental services that may be in the home, DME inventory, concise and specific treatment orders, contacting physician of record after comprehensive assessment is completed to establish plan of care and documentation requirements. If deficiencies are discovered on clinical record audits, additional education will be provided. The	

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure visits were made as ordered on the plan of care for, oxygen settings were obtained and documented weekly, and there were orders for the care provided for 4 of 10 records reviewed (#1, 2, 4, and 6) creating the potential to affect all patients currently receiving services from the agency.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/17/10, included a plan of care established by a physician for the certification period of 05/28/14 to 07/26/14 with orders for home health aide services 4 times a week for 1 week, 7 times a week for 8 weeks, 4 hours a day. The clinical record failed to evidence home health aide visits on 6/07/14 and 06/08/14.</p>	G000158	<p>Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Director of Nurses has instructed staff on the requirement of notification to the physician of any deviation from plan of care, including missed visits, frequency and duration changes. The Director of Nurses has instructed the RN case managers on the requirement to consult with physician after the comprehensive assessment is completed to establish a plan of care either through verbal or written notice. Regularly scheduled meetings with professional staff and administrative staff to ensure that plan of care is being followed in regards to frequency and duration of visits. Charts have been audited for physician notification following completion of comprehensive assessment in development of plan of care; all schedule visits and documentation of scheduled visits or reason for missed visits are included in the clinical record. 10% of clinical records will be</p>	08/27/2014

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	<p>a. A physician order dated 07/13/14 stated the patient hours for home health aide services had been increased from 4 hours a day to 7 hours a day. The clinical record failed to evidence the home health aide was in the home for 7 hours a day after 07/13/14.</p> <p>b. The DoN (Director of Nursing) indicated on 07/25/14 at 2:07 PM the patient only wanted one particular home health aide for the extended hours and if she was not available, she didn't want to utilize the extra hours. The DoN was not able to locate the missing visit notes for 06/07/14 and 06/08/14.</p> <p>2. Clinical record number 2, SOC 03/29/09, included a plan of care established by a physician for the certification period of 06/28/14 to 08/2/14 with orders for respite nursing up to 60 hours a month.</p> <p>a. On 07/01/14, 12 hours of respite nursing was met.</p> <p>b. On 07/02/14, and 07/03/14, 10 hours each day of respite nursing was met.</p> <p>c. On 07/04/14, 17.75 hours of respite nursing was met.</p>		<p>audited quarterly for compliance physician notification for the development of the plan of care, any deviations from the plan of care, including missed visits, frequency and duration changes will be documented and reported to the physician. New hire orientation will include the necessity of establishing the plan of care after consultation with the physician upon completion of comprehensive assessment. Orientation will also include the documentation and notification regulations concerning changes in the plan of care. If deficiencies are discovered on clinical record audits, additional education will be provided. The Director of Nurses and the Administrator will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur</p>	

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	<p>d. On 07/05/14, 18 hours of respite nursing was met.</p> <p>e. On 07/06/14, 10 hours of respite nursing was met.</p> <p>f. For 07/07/14 to 07/19, 2 hours of respite nursing was met each day. The clinical record evidenced the 60 hours of respite hours for skilled nursing was exceeded by 07/05/14 (67.75 hours).</p> <p>3, Clinical record number 4, SOC (first services provided) 07/23/14, included a plan of care for the certification period 07/23/14 to 09/20/14 that identified the patient was to receive home health aide services. The record contained a physician's order dated 07/23/14 that stated, "Please have registered nurse [RN] assess client for home care needs." The record failed to evidence the physician had been contacted following the assessment for verbal or written orders for the care that was provided on 7/23/14 and was to be provided.</p> <p>4. Clinical record number 6, SOC 11/20/13 (first services provided), included a plan of care for the certification period 11/20/13 to 01/18/14 that identified the patient was to receive skilled nursing, home health aide,</p>			

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	<p>attendant care aide, and homemaker services. The record contained a physician's order dated 11/19/13 that stated, "RN to evaluate for home care services." The record failed to evidence the physician had been contacted following the assessment for verbal or written orders for the care that was provided on 11/20/13 and was to be provided.</p> <p>The record also included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for home health aide services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 4 hours daily to assist with bathing, dressing, grooming, meal prep and service, incontinence care, and transfer assist; attendant care services 6 days a week for 1 week, 7 days a week (sic), 5 days a week for 1 weeks up to 5 hours a daily 7 days a week to assist with meal prep and service, light housekeeping, incontinence care, and transfer assist; and homemaker services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 1 hour daily to assist with light housekeeping.</p> <p>a. The clinical record failed to evidence a home health aide made a visit</p>			

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	<p>on 06/14/15, 06/15/14, 06/27/14, 07/01/14, 07/05/14, and 07/06/14.</p> <p>b. The clinical record failed to evidence an attendant care aide made a visit on 06/14/14, 06/15/14, 07/01/14, and 07/05/14.</p> <p>c. The clinical record failed to evidence a homemaker made a visit on 06/03/14, 06/12/14, 06/14/14, 06/15/14, 06/27/14, 07/01/14, 07/05/14, and 07/06/14.</p> <p>5. Clinical record number 9, SOC (start of care) 11/23/11, included a plan of care established by a physician for the certification period of 05/11/14 to 07/09/14 with orders for skilled nursing to document O2 (oxygen) settings weekly.</p> <p>Skilled nursing visits dated 05/15/14, 05/22/14, 05/29/14, 06/05/14, and 06/12/14 failed to evidence the oxygen settings was obtained and documented weekly.</p> <p>6. The Director of Nursing was unable to provide any additional information or documentation when asked on 07/30/14 at 2:25 PM.</p> <p>7. An undated policy titled "Care Plans"</p>			

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G000159	484.18(a)  stated, "The Care Plan shall be reviewed, evaluated, and revised [minimally every sixty 60 days as needed] based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse. All changes will be communicated to appropriate staff member ... "  8. An undated policy titled "Medical Supervision" stated, "A physician Plan of Care is developed for each client at the time of admission and signed by the physician within an appropriate time frame. The physician orders shall outline the disciplines providing care and the type, frequency, and duration of services to be provided ... "  9. An undated policy titled "Physician orders" stated, "All medications, treatments, and services provided to clients must be ordered by a physician ... All medications and treatments, that are part of the client's plan of care, must be ordered by the physician .. "			

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	<p><b>PLAN OF CARE</b></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 observation, clinical record and policy review, and interview, the agency failed to ensure plan of care were revised and updated to include all durable medical equipment (DME), outside services, and specific treatment for 8 of 10 records reviewed creating the potential to affect all patients receiving services with the agency. (#1, 2, 3, 4, 5, 6, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/17/10, included a plan of care established by a physician for the certification period of 05/28/14 to 07/26/14 with orders for home health aide services 4 times a week for 1 week, 7 times a week for 8 weeks, 4 hours a day for personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check for pressure areas, assist with ambulation, transfer to - get in and out of the</p>	G000159	<p>All RN case managers educated on the requirement to have a comprehensive list of all durable medical equipment that the client has in the home and all supplemental services the client is receiving on the plan of care. The plan of care must reflect all care needs and instructions on providing the ordered care. The plan of care will accurately reflect frequency and duration of visits per discipline. Any changes to the plan of care will be reflected with an interim order. Clinical records audited for supplemental services being provided, specific care needs and instructions to complete ordered care and accurate frequency and duration of all disciplines. 10% of clinical records will be audited quarterly for accurate treatments orders, supplemental services in the home, all DME needs noted and accuracy with frequency and duration of visits for each discipline. Orientation will also include accurate development of the plan of care to include all</p>	08/27/2014

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	<p>bathroom, incontinence care, light housekeeping, and cleaning bathroom.</p> <p>a. During a home visit on 07/25/14, a nebulizer machine was observed lying on the patient's bed. The patient had indicated during the visit she has nebulizer treatments several times a day. The plan of care failed to evidence the nebulizer machine.</p> <p>b. The clinical record stated the patient was receiving meals on wheels for meal supplementation throughout the week. The plan of care failed to evidence the patient was receiving meals on wheels services.</p> <p>c. The Director of Nursing was not able to provide further information or documentation when asked on 07/25/14 at 1:30 PM.</p> <p>2. Clinical record number 2, SOC 03/29/09, included a plan of care established by a physician for the certification period of 06/28/14 to 08/2/14 with orders for skilled nursing 7 days a week for 8 weeks, then 4 days a week for 1 week for 6 hours a day to provide bathing, dressing, transfers, incontinence care, tracheotomy care, medication administration, monitor seizure activity and monitor for</p>		<p>DME, concise treatment orders and accurate frequency and duration of disciplines. If deficiencies are discovered on clinical record audits, additional education will be provided. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur</p>				

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	<p>continuous feed, monitor respiratory status closely, suction prn (as needed) with a 12 fr (french) catheter and monitor oxygen saturations and attendant care up to 60 hours a month for personal care / hygiene and light house keeping.</p> <p>a. The clinical record evidenced the certification period started on a Saturday. The plan of care failed to be revised to reflect a frequency to be 1 day a week for 1 week, 7 days a week for 8 weeks, then 4 days a week for 1 week.</p> <p>b. Upon observation and interview on 07/25/14 at 10:00 AM, Employee A, a Registered Nurse, indicated she provided g/tube care daily and tracheotomy care. Three (3) large liquid oxygen tanks were observed in the patient's room with one being utilized. The patient was observed with a trach cover with tubing to the oxygen receiving humidity. The clinical record failed to evidence treatment instructions for both the g/tube and tracheotomy care. The plan of care failed to evidence the oxygen tank were to be humidified.</p> <p>c. The plan of care evidenced the patient was to receive tube feedings and continuous water for 20 hours a day. Employee A indicated the feeding and water was taken down at 11:00 AM and</p>			

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	<p>put back up and started at 3:00 PM. The plan of care failed to evidence the times for infusion of the feedings and water.</p> <p>3. Clinical record number 3, SOC 07/10/14, included a plan of care established by a physician for the certification period of 07/10/14 to 09/07/14 with orders for skilled nursing 53 hours a week, 7 days a week to monitor TPN (total parental nutrition), central line care, intake and output every 3 hours, weekly lab draws, ostomy care, and bottled breast milk feedings every 3 hours. The skilled nurse was to provide all personal care for client; monitor closely for change in volume status; monitor skin about ostomy stoma for any redness, breakdown; change ostomy bag as needed; and provide age appropriate care and activities.</p> <p>a. Employee B, a Registered Nurse, indicated on 07/28/14 at 8:15 AM the mother is a nurse and manages the central line dressing, ostomy care, and lab draws. The plan of care failed to evidence the infusion rate and ingredients of the TPN solution, treatment instructions for the central line care, ostomy care (including wafer and bag size), and that the mother was providing these services.</p> <p>b. The clinical record evidenced</p>			

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	<p>skilled nurse visit notes where the nurse was in the home 4 to 5 days a week 10 hours a day.</p> <p>c. A Patient Communication log dated 07/14/14 indicated the mother worked from 05:00 AM to 03:30 PM, but her number of days per week would vary. The plan of care failed to be specific in the frequency of the skilled nurse visits.</p> <p>4. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide 8 days a week for 1 week, 14 days a week for 8 weeks, 6 hours a day with AM/PM visits. The plan of care failed to evidence the correct frequency of days to be provided by the home health aide in a 1 week period.</p> <p>The Director of Nursing indicated on 07/30/14 at 1:00 PM the agency wrote their frequencies to include all visits in one day since she had started working for the company.</p> <p>5. Clinical record number 5, SOC 02/12/14, included a plan of care established by a physician for the certification period 06/12/14 to 08/10/14.</p>			

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	<p>a. A discharge summary dated 04/30/14 stated the patient was receiving Darbepoet 40 mcg IV every week with dialysis. The plan of care failed to evidence that the patient was receiving the dialysis medication.</p> <p>b. A physician order dated 03/18/14 indicated services on Tuesday and Thursday were decreased for one hour due to a Medicare Agency providing home health aide services during that time. The plan of care dated 04/09/14 to 06/11/14 failed to evidence the update and revision to include the frequency changes of the home health aide.</p> <p>6. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for home health aide 6 times a week for 1 week, 7 days a week for 7 weeks, and 5 days a week for 1 week up to 4 hours daily for 7 days a week to assist with bathing, dressing, grooming, meal prep and service, incontinent care, and transfer assist; Attendant care services 6 days a week for 1 week, 7 days a week (sic), and 5 days a week for 1 week up to 5 hours daily for 7 days a week to assist with meals, prep and service, light housekeeping, incontinent care, and transfer assist; and</p>						

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NAME OF PROVIDER OR SUPPLIER  LIFE'S TOUCH HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220
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	<p>homemaker services 6 days a week for 1 week up to 1 hour daily, 7 days a week to assist with light housekeeping.</p> <p>The plan of care indicated the patient had wounds and a foley catheter. The plan of care failed to evidence the treatment orders and directions for the management of wounds, the size of the foley catheter, and if an outside agency was providing those services.</p> <p>7. Clinical record number 9, SOC 11/23/11, included a plan of care established by a physician for the certification period 05/11/14 to 07/09/14 with orders for home health aide 14 days a week for 8 weeks, 8 times a week for 1 week (2 hours a day AM visits and 2 hours a day PM visits,).</p> <p>The Director of Nursing indicated on 07/30/14 at 1:00 PM the agency wrote their frequencies to include all visits in one day since she had started working for the company.</p> <p>8. Clinical record number 10, SOC 05/28/11, included a plan of care established by a physician for the certification period of 05/12/14 to 07/10/14 with orders for skilled nursing 4 days a week for 1 week, 14 days a week for 7 weeks, 4 days a week for 1 week (2</p>			

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	<p>visits a day, 1 hour visits) for wound cleansing, assessment, measurement, dressing change, and vital signs weekly and home health aide services 6 days a week for 1 week, 21 days a week for 7 weeks, 6 days a week for 1 week (2 to 3 hours in the morning, 1 hour mid day, and 1 hour in the evening) to assist patient with personal care needs and ADL's / IADL's.</p> <p>The clinical record evidenced a physician's order from the wound center dated 06/25/14 to apply zinc oxide to peri wound, apply collagen to base of the wound, cover with calcium alginate, and abdominal pad twice a day due to incontinence. The plan of care failed to evidence specific treatment orders and directions to be provided to the patient.</p> <p>10. The Director of Nursing was not able to provide further information or documentation when asked on 07/30/14 at 2:25 PM.</p> <p>12. An undated policy titled "Care Plans" stated, "The Care Plan shall be reviewed, evaluated, and revised [minimally every sixty 60 days as needed] based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the</p>			

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G000165	<p>interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse. All changes will be communicated to appropriate staff member ... "</p> <p>13. An undated policy titled "Plan of Care" stated, "The Plan of Care shall be completed in full to include ... type, frequency, and duration of all visits / services ... Medications, treatments, and procedures ... Medical supplies and equipment required ... "</p> <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 wound treatments were administered as ordered by the physician for 1 of 10 records reviewed of patients with wounds creating the potential to affect all 3 patients with wounds within the facility. (# 10)</p>	G000165	Alternate Director of Nursing has inserviced skilled nursing staff on following physician orders as written and documentation requirements. Wound care flow sheet developed to assist with documentation. RN case managers educated on the need to communicate with all field staff any physician ordered changes in plan of care in a timely fashion.	08/27/2014

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	<p>Findings include:</p> <p>1. Clinical record number 10, start of care 05/28/11, included a plan of care established by a physician for the certification period of 05/12/14 to 07/10/14 with orders for skilled nursing for wound cleansing, assessment, measurement, dressing change, and vital signs weekly. The clinical record evidenced a physician's order from the wound center dated 06/25/14 that stated to apply zinc oxide to perineal wound, apply collagen to base of the wound, cover with calcium alginate, and cover with abdominal pad twice a day due to incontinence.</p> <p>a. Skilled nursing visit notes dated 06/25/14 (11 AM &amp; 5:30 PM), 06/26/14 (5:30 PM), 06/27/14 (5:30 PM), 06/28/14 (10 AM), 06/28/14 (5:30 PM), 06/30/14 (5:30 PM), 07/01/14 (5:30 PM), 07/02/14 (5:30 PM), 07/03/14 (5:30 PM), 07/04/14 (5:30 PM), 07/05/14 (11 AM &amp; 5:30 PM), 07/06/14 (11 AM), 07/06/14 (5:30 PM), 07/07/14 (11 AM &amp; 5:30 PM), and 07/08/14 (5:30 PM) failed to indicate the type of treatment provided to the wound or that zinc oxide was applied as ordered.</p> <p>b. Skilled nursing visit notes dated 06/20/14 (11 AM), 07/01/14 (11 AM), 07/02/14 (11 AM), 07/03/14 (11 AM),</p>		<p>Charts have been audited to ensure physician orders are being followed and documentation is provided. 10% of clinical records will be audited quarterly for compliance with following physician ordered plan of care and documentation to indicate plan of care is followed. Staff will be provided education on following the physician ordered plan of care and the necessary documentation requirements on hire. If deficiencies are discovered with clinical record audits, staff will be provided additional education. The Director of Nurses and Alternate Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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G000168	<p>and 07/08/14 (11 AM) failed to evidence that the collagen dressing was provided as ordered or that zinc oxide was applied as ordered.</p> <p>c. Skilled nursing visit note dated 07/04/14 (12:30 PM) failed to evidence that the zinc oxide was applied as ordered.</p> <p>2. The Director of Nursing was unable to provide any additional information or documentation when asked on 07/30/14 at 2:35 PM.</p> <p>3. An undated policy titled "Clinical Documentation" stated, "Agency will document each direct contact with the client ... Additional information that is pertinent to the client's care or condition may be documented on the Progress Note or Flow Sheet ...Services not provided and the reason for the missed visits will be documented and reported to the physician ... "</p>	G000168	Director of Nurses and Alternate	08/27/2014			
	484.30 SKILLED NURSING SERVICES						

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	Based on clinical record and policy review and interview, it was determined the agency failed to ensure oxygen settings were obtained and documented weekly for 1 of 10 records reviewed and failed to ensure wound treatments were administered as ordered by the physician for 1 of 10 records reviewed of patients with wounds creating the potential to affect all 3 patients with wounds within the facility (See G 170); failed to ensure the Registered Nurse regularly re-evaluates the patient nursing needs related to assessment of oxygen settings, assessments supported a change in the patient's services, and assessments were accurate in 3 of 10 records reviewed creating the potential to affect all patients who are receiving services with the agency (See G 172); failed to ensure the Registered Nurse revised and updated the plan of cares to include all durable medical equipment, outside services, specific treatment orders, and medication reminders for 8 of 10 records reviewed creating the potential to affect all patients receiving services with the agency (See G 173); failed to ensure the skilled nurse provided wound treatments as ordered by the physician for 1 of 10 records reviewed with wounds creating the potential to affect all 3 patients with wounds within the facility (See G 174); and failed to ensure the registered nurse		Director of Nurses has inserviced the skilled nursing staff on following physicians orders, communication with staff on ordered services, notification of physician for any deviation from the established plan of care, re-assessment when patients condition changes, care coordination with all outside providers of service, documentation of all DME and supplemental services on the comprehensive assessment and plan of care, accurate documentation of frequency and duration of disciplines and that skilled care has been provided as outlined in the plan of care. Clinical records have been audited to ensure physician orders are being followed, supporting documentation is completed properly, reassessments are completed for changes in the client's condition, care coordination is completed with outside providers of services, supplemental services are noted, specific care needs with concise orders to complete care needs, accurate frequency and duration for all disciplines involved in care. 10% of all clinical records will be audited quarterly for compliance with ordered physician plan of care, documentation to indicate plan of care is being followed, reassessments are completed as indicated, care coordination are completed, supplemental services are included, specific	

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G000170	<p>coordinated all agency personnel furnishing services to ensure their efforts were coordinated effectively and supported the objectives outlined in the plan of care for 3 of 10 records reviewed creating the potential to affect all patients who received more than one service from the agency or received services from another provider (See G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with 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 oxygen settings were obtained and documented weekly for 1 of 10 records reviewed (# 9) and failed to ensure wound treatments were administered as ordered by the physician for 1 of 10 records reviewed (# 10) of patients with</p>	G000170	<p>care needs with concise orders to complete care, accurate frequency and duration of all disciplines providing care. RN case managers will be educated upon hire of all the above noted items. Skilled nursing education upon hire includes documentation and following plan of care as written by physician of record. The Director of Nurses and the Alternate Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur</p> <p>Alternate Director of Nurses has inserviced skilled nursing staff on following physician orders as written and documentation requirements. Wound care flow sheet developed to assist with documentation. RN case managers educated on the need to communicate with all field staff</p>	08/27/2014

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	<p>wounds creating the potential to affect all 3 patients with wounds within the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 9, start of care 11/23/11, included a plan of care established by a physician for the certification period of 05/11/14 to 07/09/14 with orders for skilled nursing to document O2 (oxygen) settings weekly. Skilled nursing visits dated 05/15/14, 05/22/14, 05/29/14, 06/05/14, and 06/12/14 failed to evidence that oxygen settings were obtained and documented weekly.</li> <li>2. Clinical record number 10, start of care 05/28/11, included a plan of care established by a physician for the certification period of 05/12/14 to 07/10/14 with orders for skilled nursing for wound cleansing, assessment, measurement, dressing change, and vital signs weekly. The clinical record evidenced a physician's order from the wound center dated 06/25/14 that stated to apply zinc oxide to perineal wound, apply collagen to base of the wound, cover with calcium alginate, and cover with abdominal pad twice a day due to incontinence.</li> </ol>		<p>any physician ordered changes in plan of care in a timely fashion. Staff educated on the need to report any deviations from the plan of care so the physician can be notified. Charts have been audited to ensure physician orders are being followed and documentation is provided. 10% of clinical records will be audited quarterly for compliance with following physician ordered plan of care and documentation to indicate plan of care is followed. Staff will be provided education on following the physician ordered plan of care and the necessary documentation requirements on hire. If deficiencies are discovered with clinical record audits, staff will be provided additional education. The Director of Nurses and Alternate Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>a. Skilled nursing visit notes dated 06/25/14 (11 AM &amp; 5:30 PM), 06/26/14 (5:30 PM), 06/27/14 (5:30 PM), 06/28/14 (10 AM), 06/28/14 (5:30 PM), 06/30/14 (5:30 PM), 07/01/14 (5:30 PM), 07/02/14 (5:30 PM), 07/03/14 (5:30 PM), 07/04/14 (5:30 PM), 07/05/14 (11 AM &amp; 5:30 PM), 07/06/14 (11 AM), 07/06/14 (5:30 PM), 07/07/14 (11 AM &amp; 5:30 PM), and 07/08/14 (5:30 PM) failed to indicate the type of treatment provided to the wound or that zinc oxide was applied as ordered.</p> <p>b. Skilled nursing visit notes dated 06/20/14 (11 AM), 07/01/14 (11 AM), 07/02/14 (11 AM), 07/03/14 (11 AM), and 07/08/14 (11 AM) failed to evidence that the collagen dressing was provided as ordered or that zinc oxide was applied as ordered.</p> <p>c. Skilled nursing visit note dated 07/04/14 (12:30 PM) failed to evidence that the zinc oxide was applied as ordered.</p> <p>3. The Director of Nursing was unable to provide any additional information or documentation when asked on 07/30/14 at 2:35 PM.</p> <p>4. An undated policy titled "Care Plans" stated, "The Care Plan shall be reviewed, evaluated, and revised [minimally every</p>			

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G000172	<p>sixty 60 days as needed] based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse. All changes will be communicated to appropriate staff member ... "</p> <p>5. An undated policy titled "Clinical Documentation" stated, "Agency will document each direct contact with the client ... Additional information that is pertinent to the client's care or condition may be documented on the Progress Note or Flow Sheet ... Services not provided and the reason for the missed visits will be documented and reported to the physician ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse regularly re-evaluates the patient nursing needs related to assessment of oxygen settings,</p>	G000172	Director of Nurses has educated all RN case managers on the need to complete a re-assessment for any changes in client's condition. Based upon assessment findings a change in	08/27/2014			

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	<p>assessments supported a change in the patient's services, and assessments were accurate in 3 of 10 records reviewed creating the potential to affect all patients who are receiving services with the agency. (# 1, 5, and 9)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/17/10, included a plan of care established by a physician for the certification period of 05/28/14 to 07/26/14 with orders for home health aide services 4 times a week for 1 week, 7 times a week for 8 weeks, 4 hours a day 7 days a week for personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check for pressure areas, assist with ambulation, transfer to - get in and out of the bathroom, incontinence care, light housekeeping, and cleaning bathroom. A physicians order dated 06/25/14 stated "Secondary to increasing weakness and shortness of breath, requesting additional 2 hrs [hours] / 7 days a week home health aide to assist with meal preparation and personal needs as indicated." The clinical record failed to evidence that an assessment had been provided by a skilled nurse to suggest that the patient was having increase weakness and shortness of breath. A physician's order dated 07/13/14 stated</p>		<p>plan of care may be indicated. Coordination of client services with dialysis units will include schedule and frequency of treatments, access type and who is responsible for care of access and all medications given in dialysis to be included on client's medication administration record. Care coordination form developed to address all required elements. Client records have been audited for compliance with reassessment needs and coordination of client services. 10% of clinical records will be audited quarterly for compliance with reassessment needs and care coordination needs. RN case managers will be provided education on reassessment parameters and coordination of client services on hire. If deficiencies are discovered on clinical record audits, the RN case manager will be provided additional education. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>"Additional hours approved for home health aide. Client has 7 hours / 7 days a week home health aide services through 11/21/14." The clinical record failed to evidence that an assessment had been provided by a skilled nurse to suggest that the patient needed to increase their home health aide hours.</p> <p>a. The home health aide care plan dated 03/14/14 failed to evidence changes to the care plan that would had indicated the patient had a change in condition.</p> <p>b. Review of the 60 day comprehensive re-assessments dated 03/24/14 and 05/23/14 failed to evidence that the patient had a decline in health and/or functioning to substantiate the need to increase the home health aide hours.</p> <p>c. Review of the 60 day summaries dated 03/24/14, 05/23/13, and 07/22/14 indicated the patient was stable and had no falls, bleeding, hospitalizations, or ER (emergency room) visits in the certification period.</p> <p>d. The DoN (Director of Nursing) indicated on 07/25/14 at 2:07 PM the patient had requested the extended hours. The DoN reviewed the clinical record</p>			

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	<p>and was unable to provide any documentation from a skilled nurse and/or a home health aide that the patient was having shortness of breath and weakness.</p> <p>2. Clinical record number 5, SOC 02/12/14, included a plan of care established by a physician for the certification period 06/12/14 to 08/10/14 with orders for home health aide to assist patient with personal care needs and ADL's (activities of daily living), provide effective personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check pressure areas, assist with ambulation, transfer to get in / out the bathroom, medication reminder, light housekeeping, and cleaning bathroom.</p> <p>a. A discharge summary dated 04/30/14 stated the patient was in the hospital for cellulitis, hypertension, end stage renal disease, and type 2 diabetes. The discharge summary also indicated the patient was receiving dialysis treatments three times a week.</p> <p>b. A Recertification Comprehensive Assessment dated 06/10/14 stated the primary diagnosis for services was end stage renal disease. Other diagnoses provided were neurogenic bladder, cystitis, diabetes, coronary artery, fluid</p>				

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	<p>overload, hypertension, stasis ulcer, and below knee amputation. The assessment indicated the patient had two stasis ulcer wounds. The nursing diagnosis stated, "Self care deficit related to wounds and amputation" and "Risk for impaired skin integrity related to neuropathic lower extremities." The fall risk assessment indicated the patient had visual impairment, incontinent of urine, impaired functional mobility, and pain affecting level of function. The nursing diagnoses stated, "Self care deficit related to wounds and amputation" and "Risk for impaired skin integrity related to neuropathy in lower extremities." The clinical record failed to evidence the patient was receiving dialysis treatments, and failed to include the type of dialysis access for treatments.</p> <p>3. Clinical record number 9, SOC 11/23/11, included a plan of care established by a physician for the certification period of 05/11/14 to 07/09/14 with orders for skilled nursing to document O2 (oxygen) settings weekly. A skilled nurse assignment sheet updated on 05/08/14 identified the skilled nurse was to assess client and check oxygen settings.</p> <p>Skilled nursing visits dated 05/15/14, 05/22/14, 05/29/14, 06/05/14, and</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE'S TOUCH HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220
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G000173	<p>06/12/14 failed to evidence the registered nurse had assessed the oxygen settings and documented weekly.</p> <p>4. The Director of Nursing indicated on 07/30/14 at 11:00 AM the patient was non-compliant with her oxygen.</p> <p>5. An undated policy titled "Client Reassessment / Update of Comprehensive Assessment" stated the purpose was, "To identify decline or improvement in health status, modify the plan of care and document changes that may affect care and reimbursement ... Clients are reassessed when significant changes occur in their diagnosis. A significant change in diagnosis will trigger care coordination with health team members, at that time a decision is made regarding the need for reassessment ... "</p> <p>6. An undated policy titled "Skilled Nursing Services" stated "The Registered Nurse ... regularly reevaluates the client needs, and coordinates the necessary services ... initiates the plan of care and necessary revisions and updates to the plan of care and the care plan ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of</p>			

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	<p>care and necessary revisions.</p> <p>Based on observation, clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse revised and updated the plan of cares to include all durable medical equipment, outside services, specific treatment orders, and medication reminders for 8 of 10 records reviewed creating the potential to affect all patients receiving services with the agency. (#1, 2, 3, 4, 5, 6, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/17/10, included a plan of care established by a physician for the certification period of 05/28/14 to 07/26/14 with orders for home health aide services 4 times a week for 1 week, 7 times a week for 8 weeks, 4 hours a day for personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check for pressure areas, assist with ambulation, transfer to - get in and out of the bathroom, incontinence care, light housekeeping, and cleaning bathroom.</p> <p>a. The home health aide care plan dated 03/14/14 identified the home health aide was to assist with medication reminders. The registered nurse failed to update the plan of care to include</p>	G000173	<p>Director of Nurses has educated all RN case managers on the requirement to have a comprehensive list of all durable medical equipment that the client has in the home and all supplemental services the client is receiving on the plan of care. The plan of care must reflect all care needs and instructions on providing the ordered care. The plan of care will accurately reflect frequency and duration of visits per discipline. Any changes to the plan of care will be reflected with an interim order. Care coordination will be completed by RN case managers with all outside entities. RN case managers educated on the need to communicate with all field staff any physician ordered changes in plan of care in a timely fashion. Clinical records audited for supplemental services being provided, specific care needs, care coordination completed and instructions to complete ordered care and accurate frequency and duration of all disciplines. 10% of clinical records will be audited quarterly for accurate treatments orders, supplemental services in the home, all DME needs noted, accuracy with frequency and duration of visits for each discipline and care coordination has been completed. Orientation will also include accurate development of the plan of care to include all DME, concise</p>	08/27/2014
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	<p>medication reminders.</p> <p>b. During a home visit on 07/25/14, a nebulizer machine was observed lying on the patient's bed. The patient indicated during the visit the patient has nebulizer treatments several times a day. The registered nurse failed to update the plan of care to include the nebulizer equipment.</p> <p>c. The clinical record indicated the patient was receiving meals on wheels for meal supplementation throughout the week. The registered nurse failed to update the plan of care to include the meals on wheels services.</p> <p>d. The Director of Nursing was not able to provide further information or documentation when asked on 07/25/14 at 1:30 PM.</p> <p>2. Clinical record number 2, SOC 03/29/09, included a plan of care established by a physician for the certification period of 06/28/14 to 08/2/14 with orders for skilled nursing 7 days a week for 8 weeks, then 4 days a week for 1 week for 6 hours a day to provide bathing, dressing, transfers, incontinence care, tracheotomy care, medication administration, monitor seizure activity and monitor for</p>		<p>treatment orders and accurate frequency and duration of disciplines. If deficiencies are discovered on clinical record audits, additional education will be provided. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur</p>				

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	<p>continuous feed, monitor respiratory status closely, suction prn (as needed) with a 12 fr (french) catheter and monitor oxygen saturations and attendant care up to 60 hours a month for personal care / hygiene and light house keeping.</p> <p>a. The clinical record evidenced the certification period started on a Saturday. The registered nurse failed to update the plan of care to reflect a frequency to be 1 day a week for 1 week, 7 days a week for 8 weeks, then 4 days a week for 1 week.</p> <p>b. Upon observation and interview on 07/25/14 at 10:00 AM, Employee A, a Registered Nurse, indicated she provided g/tube care daily and tracheotomy care. Three large liquid oxygen tanks were observed in the patient's room with one being utilized. The patient was observed with a trach cover with tubing to the liquid oxygen receiving humidity. The registered nurse failed to update the plan of care to include the treatment instructions for both the g/tube and tracheotomy care. The registered nurse failed to update the plan of care to include the liquid oxygen tanks for humidity.</p> <p>c. The plan of care evidenced that the patient was to receive tube feedings and continuous water for 20 hours a day.</p>			

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	<p>Employee A indicated the feeding and water were taken down at 11:00 AM and put back up and started at 3:00 PM. The registered nurse failed to update the plan of care to include the times for infusion of the feedings and water.</p> <p>3. Clinical record number 3, SOC 07/10/14, included a plan of care established by a physician for the certification period of 07/10/14 to 09/07/14 with orders for skilled nursing 53 hours a week to monitor TPN (total parental nutrition), provide central line care, measure intake and output every 3 hours, provide weekly lab draws, provide ostomy care, provide bottled breast milk feedings every 3 hours, provide all personal care for client, monitor closely for change in volume status, monitor skin about ostomy stoma for any redness / breakdown, change ostomy bag as needed, provide age appropriate care and activities, and complete central line dressing changes and cap changes.</p> <p>Employee B, a Registered Nurse, indicated on 07/28/14 at 8:15 AM the mother is a nurse and manages the central line dressing, ostomy care, and lab draws. The registered nurse failed to update the plan of care to include the infusion rate and ingredients of the TPN solution, treatment instructions for the central line</p>						

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	<p>care, ostomy care [including wafer and bag size], and that the mother was providing these services.</p> <p>4. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide 8 days a week for 1 week, 14 days a week for 8 weeks, 6 hours a day with AM/PM visits. The registered nurse failed to update the plan of care to include the correct frequency of days to be provided by the home health aide in a 1 week period.</p> <p>The Director of Nursing indicated on 07/30/14 at 1:00 PM the agency wrote their frequencies to include all visits in one day since she had started working for the company.</p> <p>5. Clinical record number 5, SOC 02/12/14, included a plan of care established by a physician for the certification period 06/12/14 to 08/10/14.</p> <p>a. A discharge summary dated 04/30/14 indicated the patient was receiving darbepoetin 40 mcg IV every week with dialysis. The registered nurse failed to update the plan of care to include the patient was receiving the dialysis medication.</p>			

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	<p>b. A physician order dated 03/18/14 indicated that services on Tuesday and Thursday was decreased for one hour due to a Medicare Agency providing home health aide services during that time. The registered nurse failed to update the plan of care to include the changes of the home health aide.</p> <p>6. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for home health aide 6 times a week for 1 week, 7 days a week for 7 weeks, and 5 days a week for 1 week up to 4 hours daily to assist with bathing, dressing, grooming, meal prep and service, incontinent care, and transfer assist; Attendant care services 6 days a week for 1 week, 7 days a week [sic], and 5 days a week for 1 week up to 5 hours daily to assist with meals, prep and service, light housekeeping, incontinent care, and transfer assist; and homemaker services 6 days a week for 1 week up to 1 hour daily to assist with light housekeeping.</p> <p>The plan of care indicated the patient had wounds and a foley catheter. The registered nurse failed to update the plan of care to include the treatment orders</p>			
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	<p>and directions for the management of wounds, the size of the foley catheter, and if an outside agency was providing those services.</p> <p>7. Clinical record number 9, SOC 11/23/11, included a plan of care established by a physician for the certification period 05/11/14 to 07/09/14 with orders for home health aide 14 days a week for 8 weeks, 8 times a week for 1 week (2 hours a day AM visits and 2 hours a day PM visits). The registered nurse failed to update the plan of care to include the specific days services would be provided by the home health aide and attendant care aide.</p> <p>The Director of Nursing indicated on 07/30/14 at 1:00 PM the agency wrote their frequencies to include all visits in one day since she had started working for the company.</p> <p>8. Clinical record number 10, SOC 05/28/11, included a plan of care established by a physician for the certification period of 05/12/14 to 07/10/14 with orders for skilled nursing 4 days a week for 1 week, 14 days a week for 7 weeks, 4 days a week for 1 week (2 visits a day, 1 hour visits) for wound cleansing, assessment, measurement, dressing change, and vital signs weekly</p>			

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	<p>and home health aide services 6 days a week for 1 week, 21 days a week for 7 weeks, 6 days a week for 1 week (2 to 3 hours in the morning, 1 hour mid day, and 1 hour in the evening) to assist with personal care needs and ADL's / IADL's. The registered nurse failed to update the plan of care to include the specific days services would be provided by the skilled nurse for each week.</p> <p>The clinical record evidenced a physician's order from the wound center dated 06/25/14 identified the nurse was to apply zinc oxide to peri wound, apply collagen to base of the wound, cover with calcium alginate, and abdominal pad twice a day due to incontinence. The registered nurse failed to update the plan of care to include the specific treatment orders and directions to be provided to the patient.</p> <p>9. The Director of Nursing was not able to provide further information or documentation when asked on 07/30/14 at 2:25 PM.</p> <p>10. An undated policy titled "Care Plans" stated, "The Care Plan shall be reviewed, evaluated, and revised [minimally every sixty 60 days as needed] based upon the client's health status and / or environment, ongoing</p>			

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G000174	<p>client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse. All changes will be communicated to appropriate staff member ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. Based on clinical record and policy review and interview, the agency failed to ensure the skilled nurse provided wound treatments as ordered by the physician for 1 of 1 records reviewed of patients with wounds creating the potential to affect all 3 patients with wounds within the facility. (# 10)</p> <p>Findings include:</p> <p>1. Clinical record number 10, SOC 05/28/11, included a plan of care established by a physician for the certification period of 05/12/14 to 07/10/14 with orders for skilled nursing for wound cleansing, assessment,</p>	G000174	<p>Alternate Director of Nurses inserviced skilled nursing staff on following physician orders as written and documentation requirements. Wound care flow sheet developed to assist with documentation. RN case managers educated on the need to communicate with all field staff any physician ordered changes in plan of care in a timely fashion. Charts have been audited to ensure physician orders are being followed and documentation is provided. 10% of clinical records will be audited quarterly for compliance with following physician ordered plan of care and documentation to indicate plan of care is followed. Staff will be provided education on</p>	08/27/2014

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	<p>measurement, dressing change, and vital signs weekly. The clinical record evidenced a physician's order from the wound center dated 06/25/14 that identified the nurse was to apply zinc oxide to peri wound, apply collagen to base of the wound, cover with calcium alginate, and cover with an abdominal pad twice a day due to incontinence.</p> <p>a. Skilled nursing visit notes dated 06/25/14 (11AM &amp; 5:30 PM), 06/26/14 (5:30 PM), 06/27/14 (5:30 PM), 06/28/14 (10 AM), 06/28/14 (5:30 PM), 06/30/14 (5:30 PM), 07/01/14 (5:30 PM), 07/02/14 (5:30 PM), 07/03/14 (5:30 PM), 07/04/14 (5:30 PM), 07/05/14 (11 AM &amp; 5:30 PM), 07/06/14 (11 AM), 07/06/14 (5:30 PM), 07/07/14 (11 AM &amp; 5:30 PM), and 07/08/14 (5:30 PM) failed to indicate the type of treatment provided to the wound or that zinc oxide was applied as ordered.</p> <p>b. Skilled nursing visit notes dated 06/20/14 (11 AM), 07/01/14 (11 AM), 07/02/14 (11 AM), 07/03/14 (11 AM), and 07/08/14 (11 AM) failed to evidence that the collagen dressing was provided as ordered or that zinc oxide was applied as ordered.</p> <p>c. Skilled nursing visit note dated 07/04/14 (12:30 PM) failed to evidence that the zinc oxide was applied as</p>		<p>following the physician ordered plan of care and the necessary documentation requirements on hire. If deficiencies are discovered with clinical record audits, staff will be provided additional education. The Director of Nurses and Alternate Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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G000176	<p>ordered.</p> <p>2. The Director of Nursing was unable to provide any additional information or documentation when asked on 07/30/14 at 2:35 PM.</p> <p>3. An undated policy titled "Skilled Nursing Services" stated "The Registered Nurse ... Provides services requiring specialized nursing skill and initiates appropriate preventative and rehavitlitative nursing procedures ... "</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, document, and policy review, the agency failed to ensure the registered nurse coordinated all agency personnel furnishing services to ensure their efforts were coordinated effectively and supported the objectives outlined in the plan of care for 3 of 10 records reviewed creating the potential to affect all patients who received more than one service from the agency or received services from another provider. (#4, 5, and 6)</p>	G000176	The Director of Nurses has inserviced all RN Case Managers regarding the requirement for all clients receiving services from an outside provider that a detailed care coordination must be completed. Coordination of care must include service provided with frequency and duration. Progression toward goals and schedule of caregivers. All staff providing services for clients who also receive services from another provider must clock out when the other provider is in the home. A care coordination form	08/27/2014

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	<p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide to assist patient with personal care needs and ADL's (activities of daily living), to provide effective personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check pressure areas, assist with ambulation, transfer to get in / out the bathroom, medication reminder, light housekeeping, and cleaning bathroom, 6 hours a day with AM/PM visits, 7 days a week.</p> <p>a. The plan of care stated that the patient was receiving nursing, physical, and occupational services with a skilled Medicare agency.</p> <p>b. A Coordination of Care form dated 07/23/14 stated an update was given to an employee of the outside agency on the client. The form failed to evidence specific details of the coordination in order to prevent overlapping of visits between a Medicare Agency and a Medicaid Agency.</p> <p>c. Employee C, a home health aide, indicated during the home visit on</p>		<p>has been developed to address all of the required elements. Timesheets have been modified to allow staff to clock in and out as needed. All RN case managers have been educated on the policy "Coordination of Client Services". Client records have been audited for compliance with coordination of client services. Coordination of client services with dialysis units will include schedule and frequency of treatments, access type and who is responsible for care of access and all medications given in dialysis to be included on client's medication administration record. Care coordination form developed to address all required elements. 10% of clinical records will be audited quarterly for compliance with care coordination needs. RN case managers will be provided education on coordination of client services on hire. If deficiencies are discovered on clinical record audits, the RN case manager will be provided additional education. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur</p>	

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NAME OF PROVIDER OR SUPPLIER  LIFE'S TOUCH HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220
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	<p>07/28/14 at 10:45 AM, she does not leave the patient's home and she was in the patient's home from 9 to 5.</p> <p>2. Clinical record number 5, SOC (start of care) 02/14/14, included a plan of care established by a physician for the certification period of 06/12/14 to 08/10/14 with orders for home health aide services.</p> <p>a. A Coordination of Care form dated 04/08/14 stated "[Name of Medicare Agency] in home at time of visit - Coordinated Care" and under Dialysis "Continues to do dialysis with [Initial of center]." The Medicare agency was providing wound care and therapy services. The form failed to evidence any coordination regarding the wound care and therapy services.</p> <p>b. The plan of care stated the patient was receiving outside services with a Medicare home health agency and the patient was going to a dialysis center for treatment. A Coordination of Care form dated 06/10/14 stated, "Still Attends." The form failed to evidence any coordination with the dialysis facility.</p> <p>c. A Coordination of Care form dated 06/10/14 stated, "Rep at home at time of recert - conference in home." The form</p>			

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	<p>failed to evidence any coordination regarding the wound care and therapy services.</p> <p>d. The clinical record failed to evidence the agency coordinated services with the dialysis center.</p> <p>3. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for home health aide services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 4 hours daily to assist with bathing, dressing, grooming, meal prep and service, incontinence care, and transfer assist; attendant care services 6 days a week for 1 week, 7 days a week (sic), 5 days a week for 1 week up to 5 hours a daily 7 days a week to assist with meal prep and service, light housekeeping, incontinence care, and transfer assist; and homemaker services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 1 hour daily to assist with light housekeeping.</p> <p>a. A Coordination of Care communication log dated 03/18/14 stated the Medicare skilled agency performed the patient's wound treatments 3 times a</p>			

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	<p>week, monthly foley catheter changes, B12 injections monthly, and biweekly medication set up. Life Touch Home Health requested the Medicare agency's home health aide schedule, but the Medicare skilled agency did not have a schedule and indicated they would notify Life Touch Home Health when available. The form failed to evidence any coordination regarding the problems addressed by the Medicare agency.</p> <p>b. A Coordination of Care communication log dated 04/29/14 indicated the skilled Medicare Agency still did not have a home health aide. The clinical record failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services or any coordination regarding the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>c. A Coordination of Care communication log dated 06/09/14 indicted the skilled Medicare Agency was providing IV (intravenous) antibiotic treatment for a chronic urinary tract infection. The form failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the</p>			

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	<p>wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>d. A Coordination of Care communication log dated 06/16/14 stated that the skilled Medicare Agency was to provide physical therapy services upon resumption of care and the patient was continuing to have IV antibiotics in the home. The form failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>e. Coordination of Care communication log dated 06/25/14, 07/01/14, 07/11/14, and 07/23/14 failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>4. The Director of Nursing indicated on 07/30/14 at 1:00 PM indicated she had addressed the status of issues with the</p>			

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G000337	<p>other agencies, she just hadn't written it down to prove she had established coordination of services. She also indicated she was not aware that she needed to coordinated services with the dialysis center.</p> <p>5. An undated policy titled "Coordination of Client Services" stated the purpose was "To ensure appropriate, quality care is being provided to clients, To establish effective interchange, reporting, and coordination of client care does occur, To assure that the efforts of agency personnel effectively complement one another and support the objectives outlined in the Plan of Care, to modify the plan to reflect needs or changes identified by members of the team and avoid duplication of services, to identify needs to modify the plan of care, to evaluate the adequacy of treatment and the effect of services provided, to determine the continuation of services and / or future plans of care ... "</p> <p>484.55(c) DRUG REGIMEN REVIEW</p>			

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	<p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review and interview, the agency failed to ensure the medication profile included start dates and new medicated treatment orders for 4 of 10 records reviewed creating the potential to affect all current patients receiving services within the agency. (#1, 5, 9, and 10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1, SOC (start of care) 06/17/10, included a plan of care established by a physician for the certification period of 05/28/14 to 07/26/14. The medication profile failed to evidence start dates for Combivent, Amlodipine, Famotidine, Gabapentin, Norco, Metoprolol, Albuterol, Lasix, and Warfarin.</li> <li>2. Clinical record number 5, SOC 02/12/14, included a plan of care established by a physician for the certification period of 06/12/14 to 08/10/14.</li> </ol>	G000337	<p>Director of Nurses has educated all RN case managers on the need to include start dates for all medications on the medication administration record. All medication discrepancies will be reconciled with the physician of record. Emphasis on medication reconciliation with resumption of care following hospitalization. Clinical records have been audited to ensure medication reconciliation policy is being followed. 10% of the clinical records will be audited quarterly to for compliance with accurate reconciliation of any inconsistencies in the medication regimen. If deficiencies are discovered with the clinical record audits, staff will be provided additional education. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	08/27/2014

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	<p>a. The medication profile failed to evidence start dates for Atorvastatin 40 mg by mouth at bedtime; Bisacodyl 5 mg by mouth daily as needed; Clopidagrel (Plavix) 75 mg by mouth daily; Nexium 40 mg by mouth daily; Ferrous Sulfate 325 mg by mouth three times a day; Gabapentin 300 mg by mouth twice a day; Metoprolol 25 mg by mouth twice a day; Multi-Vitamin 1 tab by mouth daily; Mirilax 17 gms (grams) in 8 ounces of water; Nystatin Powder topically under breasts daily; Norco 5/325 mg 1 tab every 4 hours as needed; Lispro sliding scale with meals; Calcium Acetate 667 mg 1 tab three times a day with meals; Regranex gel topical on wound daily; and Lantus 10 Units subcutaneously at bedtime. The medication profile failed to evidence a start and discontinued date for Vancomycin.</p> <p>b. The patient was in the hospital 04/28/14 to 04/30/14. Discharge medications include Augmentin 500/125, one tab every 24 hours for 1 day; Aspirin 81 mg (milligrams) daily; Atorvastatin 40 mg at bedtime; Darbepoet 40 mcg (micrograms) IV (intravenously) every week with dialysis; Docusate Sodium 100 mg capsule as needed; Esomeprazole 20 mg by mouth daily; Ferrous Sulfate 325 mg daily; Pregabalin 75 mg by mouth twice a day; Hydrocodone / APAP</p>						

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	<p>5 / 325 mg 2 tabs every 8 hours as needed; Glargine 10 units at bedtime; Metoprolol tartrate 25 mg twice a day; Nystatin 100 units powder twice a day; Plavix 75 mg by mouth daily; and renal Multivitamin 1 capsule by mouth daily. The clinical record failed to evidence the medication profile and discharge medications was reconciled with the physician upon resumption of care.</p> <p>3. Clinical record number 9, SOC (start of care) 11/23/11, included a plan of care established by a physician for the certification period of 05/11/14 to 07/09/14. The medication profile failed to evidence start dates for Bumetadme, Clonazepam, Digoxin, Gabapentin, Klor-Con, Levothyroxine, Mag Oxide, Multivitamin, Oxycontin ER, Sertraline HCC, Trazadone, Vitamin D2, Albuterol, Pro Air HFA, Avan, Spiriva, Fish Oil, Omeprazole, Senna Plus, Oxycodone, Flonase, and Coumadin.</p> <p>4. Clinical record number 10, SOC (start of care) 05/28/11, included a plan of care established by a physician for the certification period of 05/12/14 to 07/10/14. The medication profile failed to evidence start dates for Isentress, Norvir, Prezista, Taztia, Retrovir, Baclofen, Acyclovir, and Nystatin powder.</p>			

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N000000	<p>5. An undated policy titled "Medication Profile" stated, "The Medication Profile shall document ... Date medication ordered or care initiated ... If the physician changes the medication orders, the Nurse must add newly ordered drugs or medication changes to the Medication Profile. Discontinued medications shall be highlighted and documented as [DC] with the appropriate date ... The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication ... "</p> <p>6. An undated policy titled "Medication Reconciliation" stated "When client is discharged from the facility, the medications will be reviewed and the orders updated to reflect changes and / or continuation of previous orders ... "</p> <p>This was a State home health relicensure survey.</p> <p>Survey date: 07/24, 07/25, 07/28, 07/29, and 07/30/14.</p> <p>Facility: 011480</p>	N000000		

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N000486	<p>Medicaid Vendor: 200893000</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Census: 75</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 7, 2014</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. Based on clinical record, document, and policy review, the agency failed to ensure all agency personnel furnishing services maintained liaison and communicated with outside service providers to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care for 3 of 10 records reviewed creating the potential to affect all patients who received more than one service from the agency or received services from another provider. (#4, 5, and 6)</p> <p>Findings include:</p>	N000486	The Director of Nurses has inserviced all RN Case Managers regarding the requirement for all clients receiving services from another provider that a detailed care coordination must be completed. Coordination of care must include service provided with frequency and duration. Progression toward goals and schedule of caregivers. All Life's Touch Home Health care staff providing services for clients who also receive services from another provider must clock out when the other provider is in the home. A care coordination form has been developed to address all of the required elements. Timesheets are modified to allow	08/27/2014

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	<p>1. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide to assist patient with personal care needs and ADL's (activities of daily living), to provide effective personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check pressure areas, assist with ambulation, transfer to get in / out the bathroom, medication reminder, light housekeeping, and cleaning bathroom, 6 hours a day with AM/PM visits, 7 days a week.</p> <p>a. The plan of care stated that the patient was receiving nursing, physical, and occupational services with a skilled Medicare agency.</p> <p>b. A Coordination of Care form dated 07/23/14 stated an update was given to an employee of the outside agency on the client. The form failed to evidence specific details of the coordination in order to prevent overlapping of visits between a Medicare Agency and a Medicaid Agency.</p> <p>c. Employee C, a home health aide, indicated during the home visit on 07/28/14 at 10:45 AM, she does not leave the patient's home and she was in the</p>		<p>staff to clock in and out as needed. All RN case managers have been educated on the policy "Coordination of Client Services". Client records have been audited for compliance with coordination of client services. Coordination of client services with dialysis units will include schedule and frequency of treatments, access type and who is responsible for care of access and all medications given in dialysis to be included on client's medication administration record. Care coordination form developed to address all required elements. 10% of clinical records will be audited quarterly for compliance with care coordination needs. RN case managers will be provided education on coordination of client services on hire. If deficiencies are discovered on clinical record audits, the RN case manager will be provided additional education. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>patient's home from 9 to 5.</p> <p>2. Clinical record number 5, SOC (start of care) 02/14/14, included a plan of care established by a physician for the certification period of 06/12/14 to 08/10/14 with orders for home health aide services.</p> <p>a. A Coordination of Care form dated 04/08/14 stated "[Name of Medicare Agency] in home at time of visit - Coordinated Care" and under Dialysis "Continues to do dialysis with [Initial of center]." The Medicare agency was providing wound care and therapy services. The form failed to evidence any coordination regarding the wound care and therapy services.</p> <p>b. The plan of care stated the patient was receiving outside services with a Medicare home health agency and the patient was going to a dialysis center for treatment. A Coordination of Care form dated 06/10/14 stated, "Still Attends." The form failed to evidence any coordination with the dialysis facility.</p> <p>c. A Coordination of Care form dated 06/10/14 stated, "Rep at home at time of recert - conference in home." The form failed to evidence any coordination regarding the wound care and therapy</p>				

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	<p>services.</p> <p>d. The clinical record failed to evidence the agency coordinated services with the dialysis center.</p> <p>3. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for home health aide services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 4 hours daily to assist with bathing, dressing, grooming, meal prep and service, incontinence care, and transfer assist; attendant care services 6 days a week for 1 week, 7 days a week (sic), 5 days a week for 1 week up to 5 hours a daily 7 days a week to assist with meal prep and service, light housekeeping, incontinence care, and transfer assist; and homemaker services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 1 hour daily to assist with light housekeeping.</p> <p>a. A Coordination of Care communication log dated 03/18/14 stated the Medicare skilled agency performed the patient's wound treatments 3 times a week, monthly foley catheter changes, B12 injections monthly, and biweekly</p>			

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	<p>medication set up. Life Touch Home Health requested the Medicare agency's home health aide schedule, but the Medicare skilled agency did not have a schedule and indicated they would notify Life Touch Home Health when available. The form failed to evidence any coordination regarding the problems addressed by the Medicare agency.</p> <p>b. A Coordination of Care communication log dated 04/29/14 indicated the skilled Medicare Agency still did not have a home health aide. The clinical record failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services or any coordination regarding the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>c. A Coordination of Care communication log dated 06/09/14 indicted the skilled Medicare Agency was providing IV (intravenous) antibiotic treatment for a chronic urinary tract infection. The form failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or</p>				

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	<p>changes in medications during medication set up.</p> <p>d. A Coordination of Care communication log dated 06/16/14 stated that the skilled Medicare Agency was to provide physical therapy services upon resumption of care and the patient was continuing to have IV antibiotics in the home. The form failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>e. Coordination of Care communication log dated 06/25/14, 07/01/14, 07/11/14, and 07/23/14 failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>4. The Director of Nursing indicated on 07/30/14 at 1:00 PM indicated she had addressed the status of issues with the other agencies, she just hadn't written it down to prove she had established</p>				

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N000522	<p>coordination of services. She also indicated she was not aware that she needed to coordinated services with the dialysis center.</p> <p>5. An undated policy titled "Coordination of Client Services" stated the purpose was "To ensure appropriate, quality care is being provided to clients, To establish effective interchange, reporting, and coordination of client care does occur, To assure that the efforts of agency personnel effectively complement one another and support the objectives outlined in the Plan of Care, to modify the plan to reflect needs or changes identified by members of the team and avoid duplication of services, to identify needs to modify the plan of care, to evaluate the adequacy of treatment and the effect of services provided, to determine the continuation of services and / or future plans of care ... "</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and policy review and interview, the agency failed to ensure visits were made as ordered on the</p>	N000522	Director of Nurses has instructed staff on the requirement of notification to the physician of any deviation from plan of care,	08/27/2014

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	<p>plan of care for, oxygen settings were obtained and documented weekly, and there were orders for the care provided for 4 of 10 records reviewed (#1, 2, 4, and 6) creating the potential to affect all patients currently receiving services from the agency.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/17/10, included a plan of care established by a physician for the certification period of 05/28/14 to 07/26/14 with orders for home health aide services 4 times a week for 1 week, 7 times a week for 8 weeks, 4 hours a day. The clinical record failed to evidence home health aide visits on 6/07/14 and 06/08/14.</p> <p>a. A physician order dated 07/13/14 stated the patient hours for home health aide services had been increased from 4 hours a day to 7 hours a day. The clinical record failed to evidence the home health aide was in the home for 7 hours a day after 07/13/14.</p> <p>b. The DoN (Director of Nursing) indicated on 07/25/14 at 2:07 PM the patient only wanted one particular home health aide for the extended hours and if she was not available, she didn't want to</p>		<p>including missed visits, frequency and duration changes. Director of Nurses has instructed all RN case managers have on the requirement to consult with physician after the comprehensive assessment is completed to establish a plan of care either through verbal or written notice. RN case managers educated on the need to communicate with all field staff any physician ordered changes in plan of care in a timely fashion. Staff educated on the need to report any deviations from the plan of care so the physician can be notified. Regularly scheduled meetings with professional staff and administrative staff to ensure that plan of care is being followed in regards to frequency and duration of visits. Charts have been audited for physician notification following completion of comprehensive assessment in development of plan of care; all schedule visits and documentation of scheduled visits or reason for missed visits are included in the clinical record and any deviations from the plan of care. 10% of clinical records will be audited quarterly for compliance physician notification for the development of the plan of care, any deviations from the plan of care, including missed visits, frequency and duration changes will be documented and reported to the physician. New hire orientation will include the</p>	

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	<p>utilize the extra hours. The DoN was not able to locate the missing visit notes for 06/07/14 and 06/08/14.</p> <p>2. Clinical record number 2, SOC 03/29/09, included a plan of care established by a physician for the certification period of 06/28/14 to 08/2/14 with orders for respite nursing up to 60 hours a month.</p> <p>a. On 07/01/14, 12 hours of respite nursing was met.</p> <p>b. On 07/02/14, and 07/03/14, 10 hours each day of respite nursing was met.</p> <p>c. On 07/04/14, 17.75 hours of respite nursing was met.</p> <p>d. On 07/05/14, 18 hours of respite nursing was met.</p> <p>e. On 07/06/14, 10 hours of respite nursing was met.</p> <p>f. For 07/07/14 to 07/19, 2 hours of respite nursing was met each day. The clinical record evidenced the 60 hours of respite hours for skilled nursing was exceeded by 07/05/14 (67.75 hours).</p> <p>3, Clinical record number 4, SOC (first</p>		<p>necessity of establishing the plan of care after consultation with the physician upon completion of comprehensive assessment. Orientation will also include the documentation and notification regulations concerning changes in the plan of care. If deficiencies are discovered on clinical record audits, additional education will be provided. The Director of Nurses and the Administrator will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur</p>	

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	<p>services provided) 07/23/14, included a plan of care for the certification period 07/23/14 to 09/20/14 that identified the patient was to receive home health aide services. The record contained a physician's order dated 07/23/14 that stated, "Please have registered nurse [RN] assess client for home care needs." The record failed to evidence the physician had been contacted following the assessment for verbal or written orders for the care that was provided on 7/23/14 and was to be provided.</p> <p>4. Clinical record number 6, SOC 11/20/13 (first services provided), included a plan of care for the certification period 11/20/13 to 01/18/14 that identified the patient was to receive skilled nursing, home health aide, attendant care aide, and homemaker services. The record contained a physician's order dated 11/19/13 that stated, "RN to evaluate for home care services." The record failed to evidence the physician had been contacted following the assessment for verbal or written orders for the care that was provided on 11/20/13 and was to be provided.</p> <p>The record also included a plan of care established by a physician for the certification period of 05/19/14 to</p>			

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	<p>07/17/14 with orders for home health aide services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 4 hours daily to assist with bathing, dressing, grooming, meal prep and service, incontinence care, and transfer assist; attendant care services 6 days a week for 1 week, 7 days a week (sic), 5 days a week for 1 weeks up to 5 hours a daily 7 days a week to assist with meal prep and service, light housekeeping, incontinence care, and transfer assist; and homemaker services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 1 hour daily to assist with light housekeeping.</p> <p>a. The clinical record failed to evidence a home health aide made a visit on 06/14/15, 06/15/14, 06/27/14, 07/01/14, 07/05/14, and 07/06/14.</p> <p>b. The clinical record failed to evidence an attendant care aide made a visit on 06/14/14, 06/15/14, 07/01/14, and 07/05/14.</p> <p>c. The clinical record failed to evidence a homemaker made a visit on 06/03/14, 06/12/14, 06/14/14, 06/15/14, 06/27/14, 07/01/14, 07/05/14, and 07/06/14.</p>						

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	<p>5. Clinical record number 9, SOC (start of care) 11/23/11, included a plan of care established by a physician for the certification period of 05/11/14 to 07/09/14 with orders for skilled nursing to document O2 (oxygen) settings weekly.</p> <p>Skilled nursing visits dated 05/15/14, 05/22/14, 05/29/14, 06/05/14, and 06/12/14 failed to evidence the oxygen settings was obtained and documented weekly.</p> <p>6. The Director of Nursing was unable to provide any additional information or documentation when asked on 07/30/14 at 2:25 PM.</p> <p>7. An undated policy titled "Care Plans" stated, "The Care Plan shall be reviewed, evaluated, and revised [minimally every sixty 60 days as needed] based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse. All changes will be communicated to appropriate staff member ... "</p> <p>8. An undated policy titled "Medical</p>			

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N000524	<p>Supervision" stated, "A physician Plan of Care is developed for each client at the time of admission and signed by the physician within an appropriate time frame. The physician orders shall outline the disciplines providing care and the type, frequency, and duration of services to be provided ... "</p> <p>9. An undated policy titled "Physician orders" stated, "All medications, treatments, and services provided to clients must be ordered by a physician ... All medications and treatments, that are part of the client's plan of care, must be ordered by the physician .. "</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted.</p>			

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	<p>(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 observation, clinical record and policy review, and interview, the agency failed to ensure plan of care were revised and updated to include all durable medical equipment (DME), outside services, and specific treatment for 8 of 10 records reviewed creating the potential to affect all patients receiving services with the agency. (#1, 2, 3, 4, 5, 6, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/17/10, included a plan of care established by a physician for the certification period of 05/28/14 to 07/26/14 with orders for home health aide services 4 times a week for 1 week, 7 times a week for 8 weeks, 4 hours a day for personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check for pressure areas, assist with ambulation, transfer to - get in and out of the bathroom, incontinence care, light housekeeping, and cleaning bathroom.</p>	N000524	<p>Director of Nurses has educated all RN case managers on the requirement to have a comprehensive list of all durable medical equipment that the client has in the home and all supplemental services the client is receiving on the plan of care. The plan of care must reflect all care needs and instructions on providing the ordered care. The plan of care will accurately reflect frequency and duration of visits per discipline. Any changes to the plan of care will be reflected with an interim order. Care coordination will be completed by RN case managers with all outside entities. RN case managers educated on the need to communicate with all field staff any physician ordered changes in plan of care in a timely fashion. Clinical records audited for supplemental services being provided, specific care needs, care coordination completed and instructions to complete ordered care and accurate frequency and duration of all disciplines. 10% of clinical records will be audited quarterly for accurate treatments orders, supplemental services in</p>	08/27/2014

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	<p>a. During a home visit on 07/25/14, a nebulizer machine was observed lying on the patient's bed. The patient had indicated during the visit she has nebulizer treatments several times a day. The plan of care failed to evidence the nebulizer machine.</p> <p>b. The clinical record stated the patient was receiving meals on wheels for meal supplementation throughout the week. The plan of care failed to evidence the patient was receiving meals on wheels services.</p> <p>c. The Director of Nursing was not able to provide further information or documentation when asked on 07/25/14 at 1:30 PM.</p> <p>2. Clinical record number 2, SOC 03/29/09, included a plan of care established by a physician for the certification period of 06/28/14 to 08/2/14 with orders for skilled nursing 7 days a week for 8 weeks, then 4 days a week for 1 week for 6 hours a day to provide bathing, dressing, transfers, incontinence care, tracheotomy care, medication administration, monitor seizure activity and monitor for continuous feed, monitor respiratory status closely, suction prn (as needed) with a 12 fr (french) catheter and monitor</p>		<p>the home, all DME needs noted, accuracy with frequency and duration of visits for each discipline and care coordination has been completed. Orientation will also include accurate development of the plan of care to include all DME, concise treatment orders and accurate frequency and duration of disciplines. If deficiencies are discovered on clinical record audits, additional education will be provided. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur</p>	

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	<p>oxygen saturations and attendant care up to 60 hours a month for personal care / hygiene and light house keeping.</p> <p>a. The clinical record evidenced the certification period started on a Saturday. The plan of care failed to be revised to reflect a frequency to be 1 day a week for 1 week, 7 days a week for 8 weeks, then 4 days a week for 1 week.</p> <p>b. Upon observation and interview on 07/25/14 at 10:00 AM, Employee A, a Registered Nurse, indicated she provided g/tube care daily and tracheotomy care. Three (3) large liquid oxygen tanks were observed in the patient's room with one being utilized. The patient was observed with a trach cover with tubing to the oxygen receiving humidity. The clinical record failed to evidence treatment instructions for both the g/tube and tracheotomy care. The plan of care failed to evidence the oxygen tank were to be humidified.</p> <p>c. The plan of care evidenced the patient was to receive tube feedings and continuous water for 20 hours a day. Employee A indicated the feeding and water was taken down at 11:00 AM and put back up and started at 3:00 PM. The plan of care failed to evidence the times for infusion of the feedings and water.</p>			

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	<p>3. Clinical record number 3, SOC 07/10/14, included a plan of care established by a physician for the certification period of 07/10/14 to 09/07/14 with orders for skilled nursing 53 hours a week, 7 days a week to monitor TPN (total parental nutrition), central line care, intake and output every 3 hours, weekly lab draws, ostomy care, and bottled breast milk feedings every 3 hours. The skilled nurse was to provide all personal care for client; monitor closely for change in volume status; monitor skin about ostomy stoma for any redness, breakdown; change ostomy bag as needed; and provide age appropriate care and activities.</p> <p>a. Employee B, a Registered Nurse, indicated on 07/28/14 at 8:15 AM the mother is a nurse and manages the central line dressing, ostomy care, and lab draws. The plan of care failed to evidence the infusion rate and ingredients of the TPN solution, treatment instructions for the central line care, ostomy care (including wafer and bag size), and that the mother was providing these services.</p> <p>b. The clinical record evidenced skilled nurse visit notes where the nurse was in the home 4 to 5 days a week 10 hours a day.</p>						

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	<p>c. A Patient Communication log dated 07/14/14 indicated the mother worked from 05:00 AM to 03:30 PM, but her number of days per week would vary. The plan of care failed to be specific in the frequency of the skilled nurse visits.</p> <p>4. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide 8 days a week for 1 week, 14 days a week for 8 weeks, 6 hours a day with AM/PM visits. The plan of care failed to evidence the correct frequency of days to be provided by the home health aide in a 1 week period.</p> <p>The Director of Nursing indicated on 07/30/14 at 1:00 PM the agency wrote their frequencies to include all visits in one day since she had started working for the company.</p> <p>5. Clinical record number 5, SOC 02/12/14, included a plan of care established by a physician for the certification period 06/12/14 to 08/10/14.</p> <p>a. A discharge summary dated 04/30/14 stated the patient was receiving Darbepoet 40 mcg IV every week with</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE'S TOUCH HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220
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	<p>dialysis. The plan of care failed to evidence that the patient was receiving the dialysis medication.</p> <p>b. A physician order dated 03/18/14 indicated services on Tuesday and Thursday were decreased for one hour due to a Medicare Agency providing home health aide services during that time. The plan of care dated 04/09/14 to 06/11/14 failed to evidence the update and revision to include the frequency changes of the home health aide.</p> <p>6. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for home health aide 6 times a week for 1 week, 7 days a week for 7 weeks, and 5 days a week for 1 week up to 4 hours daily for 7 days a week to assist with bathing, dressing, grooming, meal prep and service, incontinent care, and transfer assist; Attendant care services 6 days a week for 1 week, 7 days a week (sic), and 5 days a week for 1 week up to 5 hours daily for 7 days a week to assist with meals, prep and service, light housekeeping, incontinent care, and transfer assist; and homemaker services 6 days a week for 1 week up to 1 hour daily, 7 days a week to assist with light housekeeping.</p>			

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	<p>The plan of care indicated the patient had wounds and a foley catheter. The plan of care failed to evidence the treatment orders and directions for the management of wounds, the size of the foley catheter, and if an outside agency was providing those services.</p> <p>7. Clinical record number 9, SOC 11/23/11, included a plan of care established by a physician for the certification period 05/11/14 to 07/09/14 with orders for home health aide 14 days a week for 8 weeks, 8 times a week for 1 week (2 hours a day AM visits and 2 hours a day PM visits,).</p> <p>The Director of Nursing indicated on 07/30/14 at 1:00 PM the agency wrote their frequencies to include all visits in one day since she had started working for the company.</p> <p>8. Clinical record number 10, SOC 05/28/11, included a plan of care established by a physician for the certification period of 05/12/14 to 07/10/14 with orders for skilled nursing 4 days a week for 1 week, 14 days a week for 7 weeks, 4 days a week for 1 week (2 visits a day, 1 hour visits) for wound cleansing, assessment, measurement, dressing change, and vital signs weekly</p>			
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	<p>and home health aide services 6 days a week for 1 week, 21 days a week for 7 weeks, 6 days a week for 1 week (2 to 3 hours in the morning, 1 hour mid day, and 1 hour in the evening) to assist patient with personal care needs and ADL's / IADL's.</p> <p>The clinical record evidenced a physician's order from the wound center dated 06/25/14 to apply zinc oxide to peri wound, apply collagen to base of the wound, cover with calcium alginate, and abdominal pad twice a day due to incontinence. The plan of care failed to evidence specific treatment orders and directions to be provided to the patient.</p> <p>10. The Director of Nursing was not able to provide further information or documentation when asked on 07/30/14 at 2:25 PM.</p> <p>12. An undated policy titled "Care Plans" stated, "The Care Plan shall be reviewed, evaluated, and revised [minimally every sixty 60 days as needed] based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered</p>			

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N000537	<p>Nurse. All changes will be communicated to appropriate staff member ... "</p> <p>13. An undated policy titled "Plan of Care" stated, "The Plan of Care shall be completed in full to include ... type, frequency, and duration of all visits / services ... Medications, treatments, and procedures ... Medical supplies and equipment required ... "</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 oxygen settings were obtained and documented weekly for 1 of 10 records reviewed (# 9) and failed to ensure wound treatments were administered as ordered by the physician for 1 of 10 records reviewed (# 10) of patients with wounds creating the potential to affect all 3 patients with wounds within the facility.</p> <p>Findings include:</p>	N000537	<p>Alternate Director of Nurses has inserviced skilled nursing staff on following physician orders as written and documentation requirements. Wound care flow sheet developed to assist with documentation. Director of Nusess has educated all RN case managers on the need to communicate with all field staff any physician ordered changes in plan of care in a timely fashion. Staff educated on the need to report any deviations from the plan of care so the physician can be notified. Clinical records have been audited to ensure physician</p>	08/27/2014

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	<p>1. Clinical record number 9, start of care 11/23/11, included a plan of care established by a physician for the certification period of 05/11/14 to 07/09/14 with orders for skilled nursing to document O2 (oxygen) settings weekly. Skilled nursing visits dated 05/15/14, 05/22/14, 05/29/14, 06/05/14, and 06/12/14 failed to evidence that oxygen settings were obtained and documented weekly.</p> <p>2. Clinical record number 10, start of care 05/28/11, included a plan of care established by a physician for the certification period of 05/12/14 to 07/10/14 with orders for skilled nursing for wound cleansing, assessment, measurement, dressing change, and vital signs weekly. The clinical record evidenced a physician's order from the wound center dated 06/25/14 that stated to apply zinc oxide to perineal wound, apply collagen to base of the wound, cover with calcium alginate, and cover with abdominal pad twice a day due to incontinence.</p> <p>a. Skilled nursing visit notes dated 06/25/14 (11 AM &amp; 5:30 PM), 06/26/14 (5:30 PM), 06/27/14 (5:30 PM), 06/28/14 (10 AM), 06/28/14 (5:30 PM), 06/30/14 (5:30 PM), 07/01/14 (5:30 PM), 07/02/14</p>		<p>orders are being followed and documentation is provided. 10% of clinical records will be audited quarterly for compliance with following physician ordered plan of care and documentation to indicate plan of care is followed. Staff will be provided education on following the physician ordered plan of care and the necessary documentation requirements on hire. If deficiencies are discovered with clinical record audits, staff will be provided additional education. The Director of Nurses and Alternate Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>(5:30 PM), 07/03/14 (5:30 PM), 07/04/14 (5:30 PM), 07/05/14 (11 AM &amp; 5:30 PM), 07/06/14 (11 AM), 07/06/14 (5:30 PM), 07/07/14 (11 AM &amp; 5:30 PM), and 07/08/14 (5:30 PM) failed to indicate the type of treatment provided to the wound or that zinc oxide was applied as ordered.</p> <p>b. Skilled nursing visit notes dated 06/20/14 (11 AM), 07/01/14 (11 AM), 07/02/14 (11 AM), 07/03/14 (11 AM), and 07/08/14 (11 AM) failed to evidence that the collagen dressing was provided as ordered or that zinc oxide was applied as ordered.</p> <p>c. Skilled nursing visit note dated 07/04/14 (12:30 PM) failed to evidence that the zinc oxide was applied as ordered.</p> <p>3. The Director of Nursing was unable to provide any additional information or documentation when asked on 07/30/14 at 2:35 PM.</p> <p>4. An undated policy titled "Care Plans" stated, "The Care Plan shall be reviewed, evaluated, and revised [minimally every sixty 60 days as needed] based upon the client's health status and / or environment, ongoing client assessments, caregiver support systems, and the effectiveness of the interventions in</p>			

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N000541	<p>achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse. All changes will be communicated to appropriate staff member ... "</p> <p>5. An undated policy titled "Clinical Documentation" stated, "Agency will document each direct contact with the client ... Additional information that is pertinent to the client's care or condition may be documented on the Progress Note or Flow Sheet ... Services not provided and the reason for the missed visits will be documented and reported to the physician ... "</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 and policy review and interview, the agency failed to ensure the Registered Nurse regularly re-evaluates the patient nursing needs related to assessment of oxygen settings, assessments supported a change in the patient's services, and assessments were accurate in 3 of 10 records reviewed</p>	N000541	The Director of Nuses has educated all RN case managers on the need to complete a re-assessment for any changes in client's condition. Based upon assessment findings a change in plan of care may be indicated. Documentation will reflect specific observations as outlined in the plan of care. Coordination of	08/27/2014

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	<p>creating the potential to affect all patients who are receiving services with the agency. (# 1, 5, and 9)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/17/10, included a plan of care established by a physician for the certification period of 05/28/14 to 07/26/14 with orders for home health aide services 4 times a week for 1 week, 7 times a week for 8 weeks, 4 hours a day 7 days a week for personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check for pressure areas, assist with ambulation, transfer to - get in and out of the bathroom, incontinence care, light housekeeping, and cleaning bathroom. A physicians order dated 06/25/14 stated "Secondary to increasing weakness and shortness of breath, requesting additional 2 hrs [hours] / 7 days a week home health aide to assist with meal preparation and personal needs as indicated." The clinical record failed to evidence that an assessment had been provided by a skilled nurse to suggest that the patient was having increase weakness and shortness of breath. A physician's order dated 07/13/14 stated "Additional hours approved for home health aide. Client has 7 hours / 7 days a week home health aide services through</p>		<p>client services with dialysis units will include schedule and frequency of treatments, access type and who is responsible for care of access and all medications given in dialysis to be included on client's medication administration record. Care coordination form developed to address all required elements. Client records have been audited for compliance with reassessment needs and coordination of client services. 10% of clinical records will be audited quarterly for compliance with reassessment needs and care coordination needs. RN case managers will be provided education on reassessment parameters and coordination of client services on hire. If deficiencies are discovered on clinical record audits, the RN case manager will be provided additional education. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>11/21/14." The clinical record failed to evidence that an assessment had been provided by a skilled nurse to suggest that the patient needed to increase their home health aide hours.</p> <p>a. The home health aide care plan dated 03/14/14 failed to evidence changes to the care plan that would had indicated the patient had a change in condition.</p> <p>b. Review of the 60 day comprehensive re-assessments dated 03/24/14 and 05/23/14 failed to evidence that the patient had a decline in health and/or functioning to substantiate the need to increase the home health aide hours.</p> <p>c. Review of the 60 day summaries dated 03/24/14, 05/23/13, and 07/22/14 indicated the patient was stable and had no falls, bleeding, hospitalizations, or ER (emergency room) visits in the certification period.</p> <p>d. The DoN (Director of Nursing) indicated on 07/25/14 at 2:07 PM the patient had requested the extended hours. The DoN reviewed the clinical record and was unable to provide any documentation from a skilled nurse and/or a home health aide that the patient</p>			

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	<p>was having shortness of breath and weakness.</p> <p>2. Clinical record number 5, SOC 02/12/14, included a plan of care established by a physician for the certification period 06/12/14 to 08/10/14 with orders for home health aide to assist patient with personal care needs and ADL's (activities of daily living), provide effective personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check pressure areas, assist with ambulation, transfer to get in / out the bathroom, medication reminder, light housekeeping, and cleaning bathroom.</p> <p>a. A discharge summary dated 04/30/14 stated the patient was in the hospital for cellulitis, hypertension, end stage renal disease, and type 2 diabetes. The discharge summary also indicated the patient was receiving dialysis treatments three times a week.</p> <p>b. A Recertification Comprehensive Assessment dated 06/10/14 stated the primary diagnosis for services was end stage renal disease. Other diagnoses provided were neurogenic bladder, cystitis, diabetes, coronary artery, fluid overload, hypertension, stasis ulcer, and below knee amputation. The assessment indicated the patient had two stasis ulcer</p>			

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	<p>wounds. The nursing diagnosis stated, "Self care deficit related to wounds and amputation" and "Risk for impaired skin integrity related to neuropathic lower extremities." The fall risk assessment indicated the patient had visual impairment, incontinent of urine, impaired functional mobility, and pain affecting level of function. The nursing diagnoses stated, "Self care deficit related to wounds and amputation" and "Risk for impaired skin integrity related to neuropathy in lower extremities." The clinical record failed to evidence the patient was receiving dialysis treatments, and failed to include the type of dialysis access for treatments.</p> <p>3. Clinical record number 9, SOC 11/23/11, included a plan of care established by a physician for the certification period of 05/11/14 to 07/09/14 with orders for skilled nursing to document O2 (oxygen) settings weekly. A skilled nurse assignment sheet updated on 05/08/14 identified the skilled nurse was to assess client and check oxygen settings.</p> <p>Skilled nursing visits dated 05/15/14, 05/22/14, 05/29/14, 06/05/14, and 06/12/14 failed to evidence the registered nurse had assessed the oxygen settings and documented weekly.</p>			

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N000542	<p>4. The Director of Nursing indicated on 07/30/14 at 11:00 AM the patient was non-compliant with her oxygen.</p> <p>5. An undated policy titled "Client Reassessment / Update of Comprehensive Assessment" stated the purpose was, "To identify decline or improvement in health status, modify the plan of care and document changes that may affect care and reimbursement ... Clients are reassessed when significant changes occur in their diagnosis. A significant change in diagnosis will trigger care coordination with health team members, at that time a decision is made regarding the need for reassessment ... "</p> <p>6. An undated policy titled "Skilled Nursing Services" stated "The Registered Nurse ... regularly reevaluates the client needs, and coordinates the necessary services ... initiates the plan of care and necessary revisions and updates to the plan of care and the care plan ... "</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p>			

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	<p>Based on observation, clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse revised and updated the plan of cares to include all durable medical equipment, outside services, specific treatment orders, and medication reminders for 8 of 10 records reviewed creating the potential to affect all patients receiving services with the agency. (#1, 2, 3, 4, 5, 6, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/17/10, included a plan of care established by a physician for the certification period of 05/28/14 to 07/26/14 with orders for home health aide services 4 times a week for 1 week, 7 times a week for 8 weeks, 4 hours a day for personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check for pressure areas, assist with ambulation, transfer to - get in and out of the bathroom, incontinence care, light housekeeping, and cleaning bathroom.</p> <p>a. The home health aide care plan dated 03/14/14 identified the home health aide was to assist with medication reminders. The registered nurse failed to update the plan of care to include medication reminders.</p>	N000542	<p>Director of Nurse has educated all RN case managers on the requirement to have a comprehensive list of all durable medical equipment that the client has in the home and all supplemental services the client is receiving on the plan of care. The plan of care must reflect all care needs and instructions on providing the ordered care. The plan of care will accurately reflect frequency and duration of visits per discipline. Any changes to the plan of care will be reflected with an interim order. Care coordination will be completed by RN case managers with all outside entities. RN case managers educated on the need to communicate with all field staff any physician ordered changes in plan of care in a timely fashion. Clinical records audited for supplemental services being provided, specific care needs, care coordination completed and instructions to complete ordered care and accurate frequency and duration of all disciplines. 10% of clinical records will be audited quarterly for accurate treatments orders, supplemental services in the home, all DME needs noted, accuracy with frequency and duration of visits for each discipline and care coordination has been completed. Orientation will also include accurate development of the plan of care to include all DME, concise treatment orders and accurate</p>	08/27/2014

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	<p>b. During a home visit on 07/25/14, a nebulizer machine was observed lying on the patient's bed. The patient indicated during the visit the patient has nebulizer treatments several times a day. The registered nurse failed to update the plan of care to include the nebulizer equipment.</p> <p>c. The clinical record indicated the patient was receiving meals on wheels for meal supplementation throughout the week. The registered nurse failed to update the plan of care to include the meals on wheels services.</p> <p>d. The Director of Nursing was not able to provide further information or documentation when asked on 07/25/14 at 1:30 PM.</p> <p>2. Clinical record number 2, SOC 03/29/09, included a plan of care established by a physician for the certification period of 06/28/14 to 08/2/14 with orders for skilled nursing 7 days a week for 8 weeks, then 4 days a week for 1 week for 6 hours a day to provide bathing, dressing, transfers, incontinence care, tracheotomy care, medication administration, monitor seizure activity and monitor for continuous feed, monitor respiratory</p>		frequency and duration of disciplines. If deficiencies are discovered on clinical record audits, additional education will be provided. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur	

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NAME OF PROVIDER OR SUPPLIER  LIFE'S TOUCH HOME HEALTH INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220			
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	<p>status closely, suction prn (as needed) with a 12 fr (french) catheter and monitor oxygen saturations and attendant care up to 60 hours a month for personal care / hygiene and light house keeping.</p> <p>a. The clinical record evidenced the certification period started on a Saturday. The registered nurse failed to update the plan of care to reflect a frequency to be 1 day a week for 1 week, 7 days a week for 8 weeks, then 4 days a week for 1 week.</p> <p>b. Upon observation and interview on 07/25/14 at 10:00 AM, Employee A, a Registered Nurse, indicated she provided g/tube care daily and tracheotomy care. Three large liquid oxygen tanks were observed in the patient's room with one being utilized. The patient was observed with a trach cover with tubing to the liquid oxygen receiving humidity. The registered nurse failed to update the plan of care to include the treatment instructions for both the g/tube and tracheotomy care. The registered nurse failed to update the plan of care to include the liquid oxygen tanks for humidity.</p> <p>c. The plan of care evidenced that the patient was to receive tube feedings and continuous water for 20 hours a day. Employee A indicated the feeding and</p>						

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	<p>water were taken down at 11:00 AM and put back up and started at 3:00 PM. The registered nurse failed to update the plan of care to include the times for infusion of the feedings and water.</p> <p>3. Clinical record number 3, SOC 07/10/14, included a plan of care established by a physician for the certification period of 07/10/14 to 09/07/14 with orders for skilled nursing 53 hours a week to monitor TPN (total parental nutrition), provide central line care, measure intake and output every 3 hours, provide weekly lab draws, provide ostomy care, provide bottled breast milk feedings every 3 hours, provide all personal care for client, monitor closely for change in volume status, monitor skin about ostomy stoma for any redness / breakdown, change ostomy bag as needed, provide age appropriate care and activities, and complete central line dressing changes and cap changes.</p> <p>Employee B, a Registered Nurse, indicated on 07/28/14 at 8:15 AM the mother is a nurse and manages the central line dressing, ostomy care, and lab draws. The registered nurse failed to update the plan of care to include the infusion rate and ingredients of the TPN solution, treatment instructions for the central line care, ostomy care [including wafer and</p>			

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	<p>bag size], and that the mother was providing these services.</p> <p>4. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide 8 days a week for 1 week, 14 days a week for 8 weeks, 6 hours a day with AM/PM visits. The registered nurse failed to update the plan of care to include the correct frequency of days to be provided by the home health aide in a 1 week period.</p> <p>The Director of Nursing indicated on 07/30/14 at 1:00 PM the agency wrote their frequencies to include all visits in one day since she had started working for the company.</p> <p>5. Clinical record number 5, SOC 02/12/14, included a plan of care established by a physician for the certification period 06/12/14 to 08/10/14.</p> <p>a. A discharge summary dated 04/30/14 indicated the patient was receiving darbepoetin 40 mcg IV every week with dialysis. The registered nurse failed to update the plan of care to include the patient was receiving the dialysis medication.</p>			

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	<p>b. A physician order dated 03/18/14 indicated that services on Tuesday and Thursday was decreased for one hour due to a Medicare Agency providing home health aide services during that time. The registered nurse failed to update the plan of care to include the changes of the home health aide.</p> <p>6. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for home health aide 6 times a week for 1 week, 7 days a week for 7 weeks, and 5 days a week for 1 week up to 4 hours daily to assist with bathing, dressing, grooming, meal prep and service, incontinent care, and transfer assist; Attendant care services 6 days a week for 1 week, 7 days a week [sic], and 5 days a week for 1 week up to 5 hours daily to assist with meals, prep and service, light housekeeping, incontinent care, and transfer assist; and homemaker services 6 days a week for 1 week up to 1 hour daily to assist with light housekeeping.</p> <p>The plan of care indicated the patient had wounds and a foley catheter. The registered nurse failed to update the plan of care to include the treatment orders and directions for the management of</p>			

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	<p>wounds, the size of the foley catheter, and if an outside agency was providing those services.</p> <p>7. Clinical record number 9, SOC 11/23/11, included a plan of care established by a physician for the certification period 05/11/14 to 07/09/14 with orders for home health aide 14 days a week for 8 weeks, 8 times a week for 1 week (2 hours a day AM visits and 2 hours a day PM visits). The registered nurse failed to update the plan of care to include the specific days services would be provided by the home health aide and attendant care aide.</p> <p>The Director of Nursing indicated on 07/30/14 at 1:00 PM the agency wrote their frequencies to include all visits in one day since she had started working for the company.</p> <p>8. Clinical record number 10, SOC 05/28/11, included a plan of care established by a physician for the certification period of 05/12/14 to 07/10/14 with orders for skilled nursing 4 days a week for 1 week, 14 days a week for 7 weeks, 4 days a week for 1 week (2 visits a day, 1 hour visits) for wound cleansing, assessment, measurement, dressing change, and vital signs weekly and home health aide services 6 days a</p>			

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	<p>week for 1 week, 21 days a week for 7 weeks, 6 days a week for 1 week (2 to 3 hours in the morning, 1 hour mid day, and 1 hour in the evening) to assist with personal care needs and ADL's / IADL's. The registered nurse failed to update the plan of care to include the specific days services would be provided by the skilled nurse for each week.</p> <p>The clinical record evidenced a physician's order from the wound center dated 06/25/14 identified the nurse was to apply zinc oxide to peri wound, apply collagen to base of the wound, cover with calcium alginate, and abdominal pad twice a day due to incontinence. The registered nurse failed to update the plan of care to include the specific treatment orders and directions to be provided to the patient.</p> <p>9. The Director of Nursing was not able to provide further information or documentation when asked on 07/30/14 at 2:25 PM.</p> <p>10. An undated policy titled "Care Plans" stated, "The Care Plan shall be reviewed, evaluated, and revised [minimally every sixty 60 days as needed] based upon the client's health status and / or environment, ongoing client assessments, caregiver support</p>						

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N000544	<p>systems, and the effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse. All changes will be communicated to appropriate staff member ... "</p> <p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on clinical record, document, and policy review, the agency failed to ensure all agency personnel furnishing services maintained liaison and communicated with outside service providers to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care for 4 of 10 records reviewed (#4, 5, 6, and 9), 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 10 clinical records reviewed creating the potential to</p>	N000544	The Director of Nurses has serviced all RN Case Managers regarding the requirement for all clients receiving services from another provider that detailed care coordination must be completed. Coordination of care must include service provided with frequency and duration. Progression toward goals and schedule of caregivers. All Life's Touch Home Health care staff providing services for clients who also receive services from another provider must clock out when the other provider is in the home. A care coordination form has been developed to address	08/27/2014

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	<p>affect all patients currently receiving services with the agency (# 4 and 6) creating the potential to affect all patients who received more than one service from the agency or received services from another provider.</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide to assist patient with personal care needs and ADL's [activities of daily living], to provide effective personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check pressure areas, assist with ambulation, transfer to get in / out the bathroom, medication reminder, light housekeeping, and cleaning bathroom, 6 hours a day with AM/PM visits, 7 days a week.</p> <p>a. The plan of care stated that the patient was receiving nursing, physical and occupational services with a skilled Medicare agency.</p> <p>b. A Coordination of Care form dated 07/23/14 stated a that an update was given to an employee of the outside agency on the client. The clinical record</p>		<p>all of the required elements. Timesheets are modified to allow staff to clock in and out as needed. All RN case managers have been educated on the policy "Coordination of Client Services". Coordination of client services with dialysis units will include schedule and frequency of treatments, access type and who is responsible for care of access and all medications given in dialysis to be included on client's medication administration record. Care coordination form developed to address all required elements. RN case managers have been instructed on the requirement to consult with physician after the comprehensive assessment is completed to establish a plan of care either through verbal or written notice. Client records have been audited for compliance with coordination of client services and contact with physician of record following comprehensive assessment to establish plan of care. 10% of clinical records will be audited quarterly for compliance with care coordination needs and contact with physician of record to establish plan of care. RN case managers will be provided education on coordination of client services and contacting physician of record after completion of comprehensive assessment to establish plan of care on hire. If deficiencies are discovered on clinical record audits, the RN</p>				

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	<p>failed to evidence specific details of the coordination in order to prevent overlapping of visits between a Medicare Agency and a Medicaid Agency.</p> <p>c. Employee C, a home health aide, indicated during the home visit on 07/28/14 at 10:45 AM that she does not leave the patient's home and she was in the patient's home from 9 to 5.</p> <p>d. A physician's order dated 07/23/14 stated "Please have RN assess client for home care needs." The clinical record failed to evidence that the physician had been contacted following the assessment in regards to the needs of the patient and admission for services.</p> <p>2. Clinical record number 5, SOC (start of care) 02/14/14, included a plan of care established by a physician for the certification period of 06/12/14 to 08/10/14 with orders for home health aide services.</p> <p>a. A Coordination of Care form dated 04/08/14 stated "[Name of Medicare Agency] in home at time of visit - Coordinated Care" and under Dialysis "Continues to do dialysis with [Initial of center]." The Medicare agency was providing wound care and therapy services.</p>		<p>case manager will be provided additional education. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur</p>				

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	<p>b. The plan of care stated that the patient was receiving outside services with a Medicare home health agency and that the patient was going to a dialysis center for treatment. A Coordination of Care form dated 06/10/14 stated " Still Attends."</p> <p>c. A Coordination of Care form dated 06/10/14 stated "Rep at home at time of recert - conference in home."</p> <p>d. The clinical record failed to evidence that the agency coordinated services with the dialysis center upon admission and every 60 days at the recertification period. The clinical record failed to evidence specific details of the coordination of services with the Medicare agency every 60 days at the recertification period.</p> <p>3. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for a home health aide services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 4 hours daily 7 days a week to assist with bathing, dressing, grooming, meal prep and service, incontinence care, and transfer assist;</p>			

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	<p>attendant care services 6 days a week for 1 week, 7 days a week [sic], 5 days a week for 1 weeks up to 5 hours a daily 7 days a week to assist with meal prep and service, light housekeeping, incontinence care, and transfer assist and homemaker services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 1 hour daily 7 days a week to assist with light housekeeping.</p> <p>a. A Coordination of Care communication log dated 03/18/14 stated that the Medicare skilled agency was informed of the patient's wound treatments 3 times a week, monthly foley catheter changes, B12 injections monthly, and biweekly medication set up. Request for an home health aide schedule was indicated by Life Touch Home Health but the Medicare skilled agency did not have a schedule and would notify Life Touch Home Health when available.</p> <p>b. A Coordination of Care communication log dated 04/29/14 stated that the skilled Medicare Agency still did not have a home health aide. The clinical record failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter, or changes in medications</p>				

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	<p>during medication set up.</p> <p>c. A Coordination of Care communication log dated 06/09/14 stated that the skilled Medicare Agency was providing IV (intravenous) antibiotic treatment for a chronic urinary tract infection. The clinical record failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter, or changes in medications during medication set up.</p> <p>d. A Coordination of Care communication log dated 06/16/14 stated that the skilled Medicare Agency was to provide physical therapy services upon resumption of care and the patient was continuing to have IV antibiotics in the home. The clinical record failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter, or changes in medications during medication set up.</p> <p>e. A Coordination of Care communication log dated 06/25/14, 07/01/14, 07/11/14, and 07/23/14 failed to evidence documentation to indicate if the skilled agency had found a home</p>			

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	<p>health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter, or changes in medications during medication set up.</p> <p>f. A physician's order dated 11/19/13 stated "RN [registered nurse] to evaluate for home care services." The clinical record failed to evidence that the physician had been contacted following the assessment in regards to the needs of the patient and admission for services.</p> <p>4. Clinical record number 9, SOC 11/23/11, included a plan of care established by a physician for the certification period 05/11/14 to 07/09/14 with orders for home health aide 14 days a week for 8 weeks, 8 times a week for 1 week, 2 hours a day AM visits and 2 hours a day PM visits, 7 days a week.</p> <p>5. The Director of Nursing indicated on 07/30/14 at 1:00 PM indicated she needed to write down her conversations with the agency to prove she had established coordination of services and also indicated she was not aware that she needed to coordinated services with the dialysis centers.</p> <p>6. An undated policy titled "Coordination of Client Services" stated,</p>			

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N000545	<p>the purpose "To ensure appropriate, quality care is being provided to clients, To establish effective interchange, reporting, and coordination of client care does occur, To assure that the efforts of agency personnel effectively complement one another and support the objectives outlined in the Plan of Care, to modify the plan to reflect needs or changes identified by members of the team and avoid duplication of services, to identify needs to modify the plan of care, to evaluate the adequacy of treatment and the effect of services provided, to determine the continuation of services and / or future plans of care ... "</p> <p>7. An undated policy titled "Physician orders" stated, "All medications, treatments, and services provided to clients must be ordered by a physician ... All medications and treatments, that are part of the client's plan of care, must be ordered by the physician .. "</p> <p>8. An undated policy titled "Medical Supervision" stated, Physicians will be informed, at the time their clients are admitted to the agency, of each parties' responsibilities in managing client care ... "</p>			

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NAME OF PROVIDER OR SUPPLIER  LIFE'S TOUCH HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2737 E 56TH ST STE E INDIANAPOLIS, IN 46220
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	<p>Scope of Services</p> <p>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:</p> <p>(F) Coordinate services.</p> <p>Based on clinical record, document, and policy review, the agency failed to ensure the registered nurse coordinated all agency personnel furnishing services to ensure their efforts were coordinated effectively and supported the objectives outlined in the plan of care for 3 of 10 records reviewed creating the potential to affect all patients who received more than one service from the agency or received services from another provider. (#4, 5, and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 07/23/14, included a plan of care established by a physician for the certification period 07/23/14 to 09/20/14 with orders for home health aide to assist patient with personal care needs and ADL's (activities of daily living), to provide effective personal hygiene, assist with bathing, dressing, hair care, skin / foot care, check pressure areas, assist with ambulation, transfer to get in / out the bathroom, medication reminder, light housekeeping, and cleaning bathroom, 6</p>	N000545	<p>The Director of Nurses has inserviced all RN Case Managers regarding the requirement for all clients receiving services from another provider that a detailed care coordination must be completed. Coordination of care must include service provided with frequency and duration. Progression toward goals and schedule of caregivers. All Life's Touch Home Health care staff providing services for clients who also receive services from another provider must clock out when the other provider is in the home. A care coordination form has been developed to address all of the required elements. Timesheets are modified to allow staff to clock in and out as needed. All RN case managers have been educated on the policy "Coordination of Client Services". Client records have been audited for compliance with coordination of client services. Coordination of client services with dialysis units will include schedule and frequency of treatments, access type and who is responsible for care of access and all medications given in dialysis to be included on client's medication administration record. Care</p>	08/27/2014

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	<p>hours a day with AM/PM visits, 7 days a week.</p> <p>a. The plan of care stated that the patient was receiving nursing, physical, and occupational services with a skilled Medicare agency.</p> <p>b. A Coordination of Care form dated 07/23/14 stated an update was given to an employee of the outside agency on the client. The form failed to evidence specific details of the coordination in order to prevent overlapping of visits between a Medicare Agency and a Medicaid Agency.</p> <p>c. Employee C, a home health aide, indicated during the home visit on 07/28/14 at 10:45 AM, she does not leave the patient's home and she was in the patient's home from 9 to 5.</p> <p>2. Clinical record number 5, SOC (start of care) 02/14/14, included a plan of care established by a physician for the certification period of 06/12/14 to 08/10/14 with orders for home health aide services.</p> <p>a. A Coordination of Care form dated 04/08/14 stated "[Name of Medicare Agency] in home at time of visit - Coordinated Care" and under Dialysis</p>		<p>coordination form developed to address all required elements. 10% of clinical records will be audited quarterly for compliance with care coordination needs. RN case managers will be provided education on coordination of client services on hire. If deficiencies are discovered on clinical record audits, the RN case manager will be provided additional education. The Director of Nurses will be responsible for monitoring corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>"Continues to do dialysis with [Initial of center]." The Medicare agency was providing wound care and therapy services. The form failed to evidence any coordination regarding the wound care and therapy services.</p> <p>b. The plan of care stated the patient was receiving outside services with a Medicare home health agency and the patient was going to a dialysis center for treatment. A Coordination of Care form dated 06/10/14 stated, "Still Attends." The form failed to evidence any coordination with the dialysis facility.</p> <p>c. A Coordination of Care form dated 06/10/14 stated, "Rep at home at time of recert - conference in home." The form failed to evidence any coordination regarding the wound care and therapy services.</p> <p>d. The clinical record failed to evidence the agency coordinated services with the dialysis center.</p> <p>3. Clinical record number 6, SOC 11/20/13, included a plan of care established by a physician for the certification period of 05/19/14 to 07/17/14 with orders for home health aide services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week</p>			

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	<p>for 1 week up to 4 hours daily to assist with bathing, dressing, grooming, meal prep and service, incontinence care, and transfer assist; attendant care services 6 days a week for 1 week, 7 days a week (sic), 5 days a week for 1 week up to 5 hours a daily 7 days a week to assist with meal prep and service, light housekeeping, incontinence care, and transfer assist; and homemaker services 6 days a week for 1 week, 7 days a week for 7 weeks, 5 days a week for 1 week up to 1 hour daily to assist with light housekeeping.</p> <p>a. A Coordination of Care communication log dated 03/18/14 stated the Medicare skilled agency performed the patient's wound treatments 3 times a week, monthly foley catheter changes, B12 injections monthly, and biweekly medication set up. Life Touch Home Health requested the Medicare agency's home health aide schedule, but the Medicare skilled agency did not have a schedule and indicated they would notify Life Touch Home Health when available. The form failed to evidence any coordination regarding the problems addressed by the Medicare agency.</p> <p>b. A Coordination of Care communication log dated 04/29/14 indicated the skilled Medicare Agency</p>			

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	<p>still did not have a home health aide. The clinical record failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services or any coordination regarding the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>c. A Coordination of Care communication log dated 06/09/14 indicted the skilled Medicare Agency was providing IV (intravenous) antibiotic treatment for a chronic urinary tract infection. The form failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>d. A Coordination of Care communication log dated 06/16/14 stated that the skilled Medicare Agency was to provide physical therapy services upon resumption of care and the patient was continuing to have IV antibiotics in the home. The form failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the</p>			

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	<p>wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>e. Coordination of Care communication log dated 06/25/14, 07/01/14, 07/11/14, and 07/23/14 failed to evidence documentation to indicate if the skilled agency had found a home health aide to provide services, the progress of the wounds, scheduling needs so services do not overlap, foley catheter status, or changes in medications during medication set up.</p> <p>4. The Director of Nursing indicated on 07/30/14 at 1:00 PM indicated she had addressed the status of issues with the other agencies, she just hadn't written it down to prove she had established coordination of services. She also indicated she was not aware that she needed to coordinated services with the dialysis center.</p> <p>5. An undated policy titled "Coordination of Client Services" stated the purpose was "To ensure appropriate, quality care is being provided to clients, To establish effective interchange, reporting, and coordination of client care does occur, To assure that the efforts of agency personnel effectively complement</p>			

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	one another and support the objectives outlined in the Plan of Care, to modify the plan to reflect needs or changes identified by members of the team and avoid duplication of services, to identify needs to modify the plan of care, to evaluate the adequacy of treatment and the effect of services provided, to determine the continuation of services and / or future plans of care ... "				