

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2012
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NAME OF PROVIDER OR SUPPLIER OPTIMA HOMEHEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6350 WESTHAVEN DRIVE INDIANAPOLIS, IN 46254
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N0000	<p>This visit was for an initial home health state licensure survey.</p> <p>Survey Dates: July 16 and 17, 2012.</p> <p>Facility #: 012753</p> <p>Medicaid Vendor #: N/A.</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor.</p> <p>Census by Service Type (unduplicated last 12 months): Skilled Patients: 9 Home Health Aide Only Patients: 1 Personal Care Only Patients: 0 Total: 10</p> <p>Sample: Record Review with Home Visit: 2 Record Review without Home visit: 2 Total: 4</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 20, 2012</p>	N0000		

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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N0449	<p>410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure.</p> <p>Based on clinical record review, policy review, interview, and observation, the Administrator failed to ensure the home health agency met all rules and regulations for licensure for 1 of 1 agency reviewed.</p> <p>Findings include:</p> <p>Please refer to N 522 for the administrator's failure to ensure medical care was provided in accordance with the plan of care; N 526 for the administrator's failure to ensure the physician reviewed the plan of care at least every 60 days; N 527, N 532, and N 546 for the administrator's failure to promptly alert the physician of significant physical changes observed and reported by the patient; N 542 for the administrator's failure to ensure the registered nurse revised the plan of care at least every 60 days and after a hospitalization; N 544 for the administrator's failure to ensure the</p>	N0449	<p>0449 :Hence forth, the Medical Director/Administrator will make sure all rules ,regulations, policies for licensure and continued licensure are met in all aspects of this agency. The administrator has inserviced the nursing staff about the current deficiecies, individual responsibilities to make sure we meet compliance and regulations, oversight of homehealth aids by the nurses managing patient's care and patient's update timely transmitted to the attending physician for continuity of care.Specifically, 20% of all clinical records will be audited quarterly to make sure this homehealth agency met all rules and regulations for licensure.The Administrator will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.Please see corrective actions for N0522, N0526, N0527, N0532, N0542, N0544, N0546, N0550, N0604, N0606.</p>	07/31/2012			

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	<p>registered nurse documented relevant information in the clinical notes; N 550 for the administrator's failure to ensure the registered nurse updated the home health aide plan of care every 60 days; N 604 for the administrator's failure to ensure the home health aide reported any changes observed in the patient's conditions and needs to the supervisory nurse; and N 606 for the administrator's failure to ensure the registered nurse completed a supervisory visit of the home health aide every 30 days.</p>			

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record review and interview, the home health agency failed to ensure medical care was provided in accordance with the plan of care in 2 of 2 records reviewed of patients receiving home health aide services with the potential to affect all of the agency's patients. (#1 and #4)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 5/15/12, included a Home Health Certification and Plan of Care for the Certification Period from 5/15/11 to 7/3/11 with orders that state, "HHA [Home Health Aide] 2-3x/wk x 8 wks" [2-3 times per week times 8 weeks].</p> <p>A. The record failed to evidence any HHA visits were made the week of 6/10/12. No missed visit notes or physician notification of the missed visits were found in the record.</p> <p>B. On 7/17/121 at 11:30 AM, employee</p>	N0522	<p>0522 Effective immediatly. The RN assigned to a patient will notify the Dr.with in 24 to 48 hours of any missed Home Health Aide visit or any missed Skilled Nursing visit.Thus,ensuring that medical care is provided in accordance with a patient's plan of care and in doing so will prevent negative affect to all the agency's patient's under the agency's care. The Director of Nursing and will monitor the home health care agency's assigned nurse and or home health aide visit's weekly for any missed visit's, and if any missed visit's were not properly reported to the Dr. Thus, the Director Of Nursing will assure that the assigned nurse has had proper inservicing of when to notify the Dr of a missed home visit,and take proper corrective action as mandated per home health agency policy. The Director of Nursing will be responsible for ensuring that the assigned RN to a patient is notifying the Dr. with in 24 to 48 hours of any missed Home Health aide visit or Skilled nursing visit through proper inservicing of the nursing staff on proper dead line for Dr. notification of any</p>	07/31/2012			

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	<p>A, RN [Registered Nurse]/ADON [Alternate Director of Nursing], stated, "The physician was not notified of the missed visits the week of 6/10/12."</p> <p>2. Clinical record #4, start of care 4/24/12, included a Home Health Certification and Plan of Care for the Certification Period from 4/24/11 to 6/24/11 with orders that state, "Patient is in need of home health aide services for assistance with ADL's [activities of daily living] 2-3x/wk x 9 wks up to 6 hours/wk [two to three times per week for 9 weeks up to 6 hours per week]."</p> <p>A. The record failed to evidence any HHA visits were made the week of 6/10/12. No missed visit notes or physician notification of the missed visits were found in the record.</p> <p>B. On 7/17/121 at 12:00 PM, employee A, RN/ADON, stated, "The physician was not notified of the missed visits the week of 6/10/12."</p>		missed skilled nursing and or home health aide visit's.				

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N0526	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist, and home health agency personnel as often as the severity of the patient's condition requires, but at least once every two (2) months.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure the physician reviewed the plan of care at least every 60 days in 3 of 4 records reviewed with the potential to affect all of the agency's patients. (#1, #2, and #3)</p> <p>Findings include:</p> <p>1. The policy titled "Reassessments / Recertification" policy number 4-020.1 states, "The total plan of care must be renewed at least every 60 days, or more often as warranted by the condition of the patient."</p> <p>2. The policy titled "Care Planning Process" policy number 4-001.1 states, "A written plan of care will be initiated within five (5) days of start of care and updated at least every 60 days or as patient's condition warrants ... The plan of care will be reviewed more frequently than every 60 days when a patient elects</p>	N0526	<p>0526 Effective immediatly. The Director of Nursing will assure the nurse assigned to any patient that each patient plan of care will be reviewed every 60 days as well as over see that any change to a patient's plan of care or medications be reported to the Dr. with each occurrence.The Director of nursing will follow up with assigned Nurse at minimum of every 60 days and with any change in a patient's change to a patient's plan of care through a assigned certification calander for each patient during the patient's certification period.The director of nursing is responsible for this complaince.</p>	07/31/2012			

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	<p>a transfer to another home health organization, a significant change occurs in the patient's condition, or a patient is discharged and readmitted during the same 60 day period."</p> <p>3. The policy titled "Physician Participation in Plan of Care" policy number 4-002.1 states, "The attending physician's recertification will be obtained in intervals of at least every 60 days when the patient's plan of care is reviewed, the patient recertified, and more often, if warranted ... The total plan of care is renewed more frequently when a patient elects transfer to another home health agency, a significant change occurs in the patient's condition, a patient is discharged and readmitted during the same 60-day episode."</p> <p>4. Clinical record #1, start of care 5/15/12, evidenced employee A, Registered Nurse / Alternate Director of Nursing (RN/ADON), completed a reassessment on patient #1 on 7/6/2012. The record failed to evidence a new Home Health Certification and Plan of Care was developed and sent to the physician following the 60 day reassessment. The last Home Health Certification and Plan of Care was for the certification period from 5/15/12 to</p>			

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	<p>7/3/12.</p> <p>5. Clinical record #2, start of care 6/11/12, evidenced employee A, RN/ADON, completed a resumption of care assessment (following a hospitalization) on patient #2 on 7/2/2012. The record failed to evidence a new Home Health Certification and Plan of Care was developed and sent to the physician following the resumption of care assessment. The last Home Health Certification and Plan of Care was for the certification period from 6/11/12 to 8/10/12.</p> <p>On 7/16/2012, on the way to a home visit with Employee A and patient #2, employee A indicated the patient called them on Saturday (7/14/2012) to notify employee A of several recent falls. Employee A indicated they asked the patient if they had been prescribed any new medication and the patient indicated they had recently started taking Lisinopril. Employee A indicated they instructed the patient to go to the ER [Emergency Room]. When asked if this was reported to the attending physician, Employee A indicated they had not reported it to the physician. The record also failed to evidence the plan of care was updated following the change</p>						

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	<p>in condition.</p> <p>6. Clinical record #3, start of care 5/3/12, evidenced employee A, RN/ADON, completed a reassessment on patient #3 on 7/4/2012. The record failed to evidence a new Home Health Certification and Plan of Care was developed and sent to the physician following the 60 day reassessment. The last Home Health Certification and Plan of Care was for the certification period from 5/3/12 to 6/22/12.</p> <p>7. On 7/16/2012 at 11:55 AM, employee A, RN/ADON, indicated the 485 (plan of care) was not current for any of the files that have had reassessments. Employee A indicated they updated the OASIS and sent out the 60 day summary but forgot to update the 485. Employee A indicated this was an oversight.</p>						

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N0527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure the physician was notified of changes in the patient's condition in 1 of 4 records reviewed with the potential to affect all of the agency's patients. (#2)</p> <p>Findings include:</p> <p>1. The policy titled "Monitoring Patient's Response / Reporting to Physician" policy number 4-012.1 states, "The patient's physician will be contacted on the same day when any of the following occur: ... Significant changes in the patient's condition ... Changes that have occurred regarding diagnosis, prognosis, or treatment (including procedures, medications, precautions, and limitations) ... All conferences or attempts to communicate with physician will be documented in the clinical record. ... When unable to contact the patient's physician for medical consultation warranted by change in patient's</p>	N0527	0527 RN will promptly report any change in a patient's medical status to the Dr. with each occurrence. The Director of Nursing will assure that each nurse is properly oriented on when, and why they need to promptly notify any change in a patient's medical status with each occurrence, as the homehealth agency sates Policy is to notify the Dr. the same day of any change in a Pt mental or physical status. The Director of Nursing will be responsible for ensuring the nursing staff of the homehealth agency is following proper policy and procedure of notifying the Dr of any mental or physical change in a patient's condition by reviewing patient's medical chart on a weekly basis.	07/31/2012			

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	<p>condition, the following procedures will be followed: The nurse or therapist will immediately notify the Clinical Supervisor or designee regarding the need for medical consultation and problems encountered, an attempt will be made by the clinical supervisor or designee to contact the patient's physician, if the Clinical Supervisor or designee is unable to contact the patient's physician, the Clinical Supervisor or designee will notify the organization's Medical Director of the change in patient condition and the inability to contact the patient's physician to request medical consultation. Based on the communication with the physician, a verbal order will be obtained for any change in the plan of care and communicated to all appropriate team members to ensure that care is provided according to the revised plan of care."</p> <p>2. The policy titled "Ongoing Assessments" policy number 4-019.1 states, "Re-assessments should focus on: Patient's response to care, changes in patient condition, changes in patient diagnoses ... Based on each reassessment, change/verbal orders will be generated and forwarded to the physician (or other licensed independent</p>			

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	<p>practitioner) as needed. The physician will be notified to verify any changes in medications, including over-the-counter medications (which might interact or be duplicative with other patient medications), and treatment / interventions that require physician approval."</p> <p>3. The job description titled "Registered Nurse (RN)" dated June 2011 states, "Communicates with the physician regarding the patient's needs and reports changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>4. Clinical record #2, start of care 6/11/12, evidenced a skilled nurse visit note dated 7/4/2012 that stated, "F/U [follow up] for readmission. Pt [patient] very confused disoriented today states its the 26th of June. Urinary frequency has urinated 4 times since writer there @ [at] home advising pt [patient] go back to hospital. [Patient] went to the hospital for eval et tx [evaluation and treatment]. F/U if d/c [follow-up if discharged] from hospital to home in a week to see if overall medical condition has improved." The record failed to evidence any documentation indicating the physician was notified of the change in condition.</p>						

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	<p>A. On 7/17/2012, employee A, RN/ADON, indicated they did not notify the physician of the change in patient condition. Employee A indicated they just instructed the patient to go to the hospital for evaluation.</p> <p>B. On 7/16/2012, on the way to a home visit with Employee A and patient #2, employee A indicated the patient called them on Saturday (7/14/2012) to notify employee A of several recent falls. Employee A indicated they asked the patient if they had been prescribed any new medication and the patient indicated they had recently started taking Lisinopril. Employee A indicated they instructed the patient to go to the ER [Emergency Room]. When asked if this was reported to the attending physician, Employee A indicated they had not reported it to the physician. Employee A indicated they were going to see patient #2 today to follow-up and see how they were doing. During the home visit on 7/16/2012 at 1:20 PM, the patient indicated they had fallen several times since Saturday. The patient indicated they went to the emergency room on Saturday and was released. Upon assessment, employee A took the patient's blood pressure which was</p>			

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	<p>68/40. Employee A indicated the patient's blood pressure was way too low and this is why the patient was falling. The patient stated they just started taking a new medication. Employee A asked to see the medication bottle and stated the prescription was for Lisinopril 5 MG. The patient indicated they had an appointment to see their attending physician at 1:45 PM and would like to leave so they could make the appointment in time. The patient's sister proceeded to help the patient up and on the way out of the door, the patient started to fall down. Employee A ran to assist and the patient again began to pass out. The RN and sister ambulated the patient to the couch. The patient's sister stated the patient had began to pass out, went dead weight, with eyes rolling in the back of head. The patient's sister called the attending physician and informed him the patient had low blood pressure and was falling, and would be late to the appointment. The sister indicated the office staff told her this was fine. The RN retook the patient's blood pressure and it was 68/50. The RN indicated they could not allow the patient to leave with the sister with the patient's blood pressure that low. The RN indicated an ambulance needed to be called before they could</p>			

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NAME OF PROVIDER OR SUPPLIER OPTIMA HOMEHEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6350 WESTHAVEN DRIVE INDIANAPOLIS, IN 46254
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	<p>allow the patient to leave. The patient indicated they did not want the paramedics called and would not go to the hospital. The patient indicated they wanted to go see the primary care physician] and again tried to stand up and began to pass out. The patient's sister's daughter then dialed 911 and handed the phone to the RN. The RN instructed the paramedics to come to the patient's residence. Upon arrival of the paramedics, the patient's sitting and standing blood pressure was taken. The paramedics stated the patient's standing blood pressure was 70/30 and instructed the patient they needed to go to the hospital. The patient again refused. The patient stated "I have been to the ER the past 3 days and they do nothing for me, I want to see my own doctor." The paramedics had the patient sign a refusal consent and then proceeded to push the patient out to the sister's car in a wheelchair. The patient and the sister then left to go the the patient's doctor appointment with the primary care physician.</p> <p>C. A skilled nursing visit note dated 7/16/2012 stated, "Routine F/U assess VS [follow up, vital signs] upon assessment pt [patient] hypotensive et [and] reported per self freq [frequency]</p>			

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	<p>falls. "Stated I fell 10 times yesterday. I have a Dr. appt [appointment] today. When family attempted to ambulate out of home pt had syncope episode 911 called et assessed by EMS was hypotensive refused to go to hospital did agree to go in family car to Dr. appt for evaluation et treatment. Will f/u with PCP [Primary Care Physician] et mother for pt status after visit today."</p> <p>D. On 7/17/12 at 9:40 AM, employee A entered the conference room and informed surveyor that they called patient #2 last night to follow up and patient #2 indicated they were being admitted to Methodist Hospital. When asked if employee A followed-up with the physician, employee A indicated they had not done this yet.</p>			

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N0532	<p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on policy review, clinical record review, observation, interview, and observation, the home health agency failed to promptly alert the physician of significant physical changes observed and reported by the patient in 1 of 4 records reviewed with the potential to affect all of the agency's patients. (#2)</p> <p>Findings include:</p> <p>1. The policy titled "Monitoring Patient's Response / Reporting to Physician" policy number 4-012.1 states, "The patient's physician will be contacted on the same day when any of the following occur: ... Significant changes in the patient's condition ... Changes that have occurred regarding diagnosis, prognosis, or treatment (including procedures, medications, precautions, and limitations) ... All conferences or attempts to communicate with physician</p>	N0532	0532Nurse will notify the Dr. of any change in mental or physical condition on the same day of the change in mental or physical condition occurs. The Nurse assigned to any pateint will notify the Dr the same day of any change in a patient's mental or physical condition. As the homehealth agency policy states.The Director of Nursing will be responsible for assuring that all nurses employed by the homehealth agency is properly inserviced on the protocol of the home health agency's policy for notification of the Dr. when a patient's mental or physical condition has changed.	07/31/2012			

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	<p>will be documented in the clinical record. ... When unable to contact the patient's physician for medical consultation warranted by change in patient's condition, the following procedures will be followed: The nurse or therapist will immediately notify the Clinical Supervisor or designee regarding the need for medical consultation and problems encountered, an attempt will be made by the clinical supervisor or designee to contact the patient's physician, if the Clinical Supervisor or designee is unable to contact the patient's physician, the Clinical Supervisor or designee will notify the organization's Medical Director of the change in patient condition and the inability to contact the patient's physician to request medical consultation. Based on the communication with the physician, a verbal order will be obtained for any change in the plan of care and communicated to all appropriate team members to ensure that care is provided according to the revised plan of care."</p> <p>2. The policy titled "Ongoing Assessments" policy number 4-019.1 states, "Re-assessments should focus on: Patient's response to care, changes in patient condition, changes in patient</p>			

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	<p>diagnoses ... Based on each reassessment, change/verbal orders will be generated and forwarded to the physician (or other licensed independent practitioner) as needed. The physician will be notified to verify any changes in medications, including over-the-counter medications (which might interact or be duplicative with other patient medications), and treatment / interventions that require physician approval."</p> <p>3. The job description titled "Registered Nurse (RN)" dated June 2011 states, "Communicates with the physician regarding the patient's needs and reports changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>4. Clinical record #2, start of care 6/11/12, evidenced a skilled nurse visit note dated 7/4/2012 that stated, "F/U [follow up] for readmission. Pt [patient] very confused disoriented today states its the 26th of June. Urinary frequency has urinated 4 times since writer there @ [at] home advising pt [patient] go back to hospital. [Patient] went to the hospital for eval et tx [evaluation and treatment]. F/U if d/c [follow-up if discharged] from hospital to home in a week to see if</p>			

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	<p>overall medical condition has improved." The record failed to evidence any documentation indicating the physician was notified of the change in condition.</p> <p>A. On 7/17/2012, employee A, RN/ADON, indicated they did not notify the physician of the change in patient condition. Employee A indicated they just instructed the patient to go to the hospital for evaluation.</p> <p>B. On 7/16/2012, on the way to a home visit with Employee A and patient #2, employee A indicated the patient called them on Saturday (7/14/2012) to notify employee A of several recent falls. Employee A indicated they asked the patient if they had been prescribed any new medication and the patient indicated they had recently started taking Lisinopril. Employee A indicated they instructed the patient to go to the ER [Emergency Room]. When asked if this was reported to the attending physician, Employee A indicated they had not reported it to the physician. Employee A indicated they were going to see patient #2 today to follow-up and see how they were doing. During the home visit on 7/16/2012 at 1:20 PM, the patient indicated they had fallen several times since Saturday. The patient</p>			

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	<p>indicated they went to the emergency room on Saturday and was released. Upon assessment, employee A took the patient's blood pressure which was 68/40. Employee A indicated the patient's blood pressure was way too low and this is why the patient was falling. The patient stated they just started taking a new medication. Employee A asked to see the medication bottle and stated the prescription was for Lisinopril 5 MG. The patient indicated they had an appointment to see their attending physician at 1:45 PM and would like to leave so they could make the appointment in time. The patient's sister proceeded to help the patient up and on the way out of the door, the patient started to fall down. Employee A ran to assist and the patient again began to pass out. The RN and sister ambulated the patient to the couch. The patient's sister stated the patient had began to pass out, went dead weight, with eyes rolling in the back of head. The patient's sister called the attending physician and informed him the patient had low blood pressure and was falling, and would be late to the appointment. The sister indicated the office staff told her this was fine. The RN retook the patient's blood pressure and it was 68/50. The RN indicated they could not</p>			

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	<p>allow the patient to leave with the sister with the patient's blood pressure that low. The RN indicated an ambulance needed to be called before they could allow the patient to leave. The patient indicated they did not want the paramedics called and would not go to the hospital. The patient indicated they wanted to go see the primary care physician] and again tried to stand up and began to pass out. The patient's sister's daughter then dialed 911 and handed the phone to the RN. The RN instructed the paramedics to come to the patient's residence. Upon arrival of the paramedics, the patient's sitting and standing blood pressure was taken. The paramedics stated the patient's standing blood pressure was 70/30 and instructed the patient they needed to go to the hospital. The patient again refused. The patient stated "I have been to the ER the past 3 days and they do nothing for me, I want to see my own doctor." The paramedics had the patient sign a refusal consent and then proceeded to push the patient out to the sister's car in a wheelchair. The patient and the sister then left to go the the patient's doctor appointment with the primary care physician.</p> <p>C. A skilled nursing visit note dated</p>			

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	<p>7/16/2012 stated, "Routine F/U assess VS [follow up, vital signs] upon assessment pt [patient] hypotensive et [and] reported per self freq [frequency] falls. "Stated I fell 10 times yesterday. I have a Dr. appt [appointment] today. When family attempted to ambulate out of home pt had syncope episode 911 called et assessed by EMS was hypotensive refused to go to hospital did agree to go in family car to Dr. appt for evaluation et treatment. Will f/u with PCP [Primary Care Physician] et mother for pt status after visit today."</p> <p>D. On 7/17/12 at 9:40 AM, employee A entered the conference room and informed surveyor that they called patient #2 last night to follow up and patient #2 indicated they were being admitted to Methodist Hospital. When asked if employee A followed-up with the physician, employee A indicated they had not done this yet.</p>			

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N0542	<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> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure the registered nurse revised the plan of care at least every 60 days and after a hospitalization in 4 of 4 records reviewed with the potential to affect all of the agency's patients. (#1, #2, #3, and #4)</p> <p>Findings include:</p> <p>1. The policy titled "Reassessments / Recertification" policy number 4-020.1 states, "The total plan of care must be renewed at least every 60 days, or more often as warranted by the condition of the patient."</p> <p>2. The policy titled "Care Planning Process" policy number 4-001.1 states, "A written plan of care will be initiated within five (5) days of start of care and updated at least every 60 days or as patient's condition warrants ... The plan of care will be reviewed more frequently</p>	N0542	0542RN will revise the plan of care every 60 days and with any recertification of home health services. RN will also notify the Dr. of the revised plan of care every 60 days and with any recertification of plan of care. The assigned nurse to a patient will revise the plan of care every 60 days and with any recertification of the homehealth agency's services and notify the Dr of the revised plan of care every 60 days and with any recertification of plan of care. The Director of Nursing will be responsible for educating the nurses employed with the home health agency of revision of plan of care and with any recertification of homehealth services as policy states at minimum of every 60 days and with any recertification of homehealth agency's services.	07/31/2012			

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	<p>than every 60 days when a patient elects a transfer to another home health organization, a significant change occurs in the patient's condition, or a patient is discharged and readmitted during the same 60 day period."</p> <p>3. The policy titled "Physician Participation in Plan of Care" policy number 4-002.1 states, "The attending physician's recertification will be obtained in intervals of at least every 60 days when the patient's plan of care is reviewed, the patient recertified, and more often, if warranted ... The total plan of care is renewed more frequently when a patient elects transfer to another home health agency, a significant change occurs in the patient's condition, a patient is discharged and readmitted during the same 60-day episode."</p> <p>4. Clinical record #1, start of care 5/15/12, evidenced employee A, Registered Nurse / Alternate Director of Nursing (RN/ADON), completed a reassessment on patient #1 on 7/6/2012. The record failed to evidence a new Home Health Certification and Plan of Care was developed and sent to the physician following the 60 day reassessment. The last Home Health Certification and Plan of Care was for the</p>						

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	<p>certification period from 5/15/12 to 7/3/12.</p> <p>5. Clinical record #2, start of care 6/11/12, evidenced employee A, RN/ADON, completed a resumption of care assessment (following a hospitalization) on patient #2 on 7/2/2012. The record failed to evidence a new Home Health Certification and Plan of Care was developed and sent to the physician following the resumption of care assessment. The last Home Health Certification and Plan of Care was for the certification period from 6/11/12 to 8/10/12.</p> <p>On 7/16/2012, on the way to a home visit with Employee A and patient #2, employee A indicated the patient called them on Saturday (7/14/2012) to notify employee A of several recent falls. Employee A indicated they asked the patient if they had been prescribed any new medication and the patient indicated they had recently started taking Lisinopril. Employee A indicated they instructed the patient to go to the ER [Emergency Room]. When asked if this was reported to the attending physician, Employee A indicated they had not reported it to the physician. The record also failed to evidence the plan of</p>			

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	<p>care was updated following the change in condition.</p> <p>6. Clinical record #3, start of care 5/3/12, evidenced employee A, RN/ADON, completed a reassessment on patient #3 on 7/4/2012. The record failed to evidence a new Home Health Certification and Plan of Care was developed and sent to the physician following the 60 day reassessment. The last Home Health Certification and Plan of Care was for the certification period from 5/3/12 to 6/22/12.</p> <p>7. On 7/16/2012 at 11:55 AM, employee A, RN/ADON, indicated the 485 (plan of care) was not current for any of the files that have had reassessments. Employee A indicated they updated the OASIS and sent out the 60 day summary but forgot to update the 485. Employee A indicated this was an oversight.</p>			

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N0544	<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.</p> <p>Based on document and clinical record review and interview, the home health agency failed to ensure the registered nurse documented relevant information in the clinical notes for 1 of 4 records reviewed with the potential to affect all of the agency's patients. (#2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The job description titled "Registered Nurse (RN)" dated June 2011 states, "Prepares clinical notes" 2. On 7/16/2012, on the way to a home visit with Employee A and patient #2, employee A indicated the patient called them on Saturday (7/14/2012) to notify employee A of several recent falls. Employee A indicated they asked the patient if they had been prescribed any new medication and the patient indicated they had recently started taking Lisinopril. Employee A indicated they instructed the patient to go to the 	N0544	0544Nurse will document every communication with a patient, and will properly and promptly document the communication in the clinical notes. The Nurse assigned to the patient will document every communication with the patient whether telephone or face to face in a prompt accurate manner in the patient's clinical notes. The Director of Nursing will be responsible for educating the nurses employed with the homehealth agency of prompt proper documentation of communication in the patient's clinical notes.	07/31/2012

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	<p>ER [Emergency Room]. When asked if this was reported to the attending physician, Employee A indicated they had not reported it to the physician.</p> <p>3. Clinical record #2 failed to evidence documentation of the conversation Employee A indicated having with patient #2 on 7/14/2012.</p> <p>4. On 7/17/12 at 11:38 AM, employee A indicated they had not documented this phone conversation in the medical record.</p>			

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N0546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on policy review, clinical record review, interview, and observation, the home health agency failed to ensure the registered nurse notified the physician regarding changes in the patient's condition in 1 of 4 records reviewed with the potential to affect all of the agency's patients. (#2)</p> <p>Findings include:</p> <p>1. The policy titled "Monitoring Patient's Response / Reporting to Physician" policy number 4-012.1 states, "The patient's physician will be contacted on the same day when any of the following occur: ... Significant changes in the patient's condition ... Changes that have occurred regarding diagnosis, prognosis, or treatment (including procedures, medications, precautions, and</p>	N0546	0546Nurse will notify the Dr. on the same day of notification of any change in a patient's condition regarding prognosis, diagnosis, and or treatment. If the nurse is unable to contact and speak with the Dr. the notifying nurse will contact the nurse supervisor. Then if the notifying nurse is unable to contact the nurse supervisor or designee regarding the need for medical consultation or problems encountered notifying nurse will contact the Medical director/Administrator of the home health agency. The nurse will document all of the notification made to the Dr. properly and promptly in the patient's clinical record per home health agency policies. The nurse assigned to a patient will notify the Dr on the same day of notification of any change in a patients condition regarding prognosis, diagnosis and or treatment. Thus if the	07/31/2012			

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	<p>limitations) ... All conferences or attempts to communicate with physician will be documented in the clinical record. ... When unable to contact the patient's physician for medical consultation warranted by change in patient's condition, the following procedures will be followed: The nurse or therapist will immediately notify the Clinical Supervisor or designee regarding the need for medical consultation and problems encountered, an attempt will be made by the clinical supervisor or designee to contact the patient's physician, if the Clinical Supervisor or designee is unable to contact the patient's physician, the Clinical Supervisor or designee will notify the organization's Medical Director of the change in patient condition and the inability to contact the patient's physician to request medical consultation. Based on the communication with the physician, a verbal order will be obtained for any change in the plan of care and communicated to all appropriate team members to ensure that care is provided according to the revised plan of care."</p> <p>2. The policy titled "Ongoing Assessments" policy number 4-019.1 states, "Re-assessments should focus on:</p>		<p>assigned nurse is unable to reach the Dr inform of the change in the patient condition,the assigned nures will follow the homehealth agency chain of command policy to notify the nurse supervisor if unable to reach then the assigned nurse will contact the medical director/administrator of the homehealth agency and document properly of the squence of contact made for change in a patient's condition.The Director of Nursing will be held responsible for orientationing and educating of each nurse employed with the homehealth agency of the proper chain of command for notification of a change in a patient's condition.</p>				

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	<p>Patient's response to care, changes in patient condition, changes in patient diagnoses ... Based on each reassessment, change/verbal orders will be generated and forwarded to the physician (or other licensed independent practitioner) as needed. The physician will be notified to verify any changes in medications, including over-the-counter medications (which might interact or be duplicative with other patient medications), and treatment / interventions that require physician approval."</p> <p>3. The job description titled "Registered Nurse (RN)" dated June 2011 states, "Communicates with the physician regarding the patient's needs and reports changes in the patient's condition; obtains/receives physician's orders as required."</p> <p>4. Clinical record #2, start of care 6/11/12, evidenced a skilled nurse visit note dated 7/4/2012 that stated, "F/U [follow up] for readmission. Pt [patient] very confused disoriented today states its the 26th of June. Urinary frequency has urinated 4 times since writer there @ [at] home advising pt [patient] go back to hospital. [Patient] went to the hospital for eval et tx [evaluation and treatment]."</p>						

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	<p>F/U if d/c [follow-up if discharged] from hospital to home in a week to see if overall medical condition has improved." The record failed to evidence any documentation indicating the physician was notified of the change in condition.</p> <p>A. On 7/17/2012, employee A, RN/ADON, indicated they did not notify the physician of the change in patient condition. Employee A indicated they just instructed the patient to go to the hospital for evaluation.</p> <p>B. On 7/16/2012, on the way to a home visit with Employee A and patient #2, employee A indicated the patient called them on Saturday (7/14/2012) to notify employee A of several recent falls. Employee A indicated they asked the patient if they had been prescribed any new medication and the patient indicated they had recently started taking Lisinopril. Employee A indicated they instructed the patient to go to the ER [Emergency Room]. When asked if this was reported to the attending physician, Employee A indicated they had not reported it to the physician. Employee A indicated they were going to see patient #2 today to follow-up and see how they were doing. During the home visit on 7/16/2012 at 1:20 PM, the</p>			

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	<p>patient indicated they had fallen several times since Saturday. The patient indicated they went to the emergency room on Saturday and was released. Upon assessment, employee A took the patient's blood pressure which was 68/40. Employee A indicated the patient's blood pressure was way too low and this is why the patient was falling. The patient stated they just started taking a new medication. Employee A asked to see the medication bottle and stated the prescription was for Lisinopril 5 MG. The patient indicated they had an appointment to see their attending physician at 1:45 PM and would like to leave so they could make the appointment in time. The patient's sister proceeded to help the patient up and on the way out of the door, the patient started to fall down. Employee A ran to assist and the patient again began to pass out. The RN and sister ambulated the patient to the couch. The patient's sister stated the patient had began to pass out, went dead weight, with eyes rolling in the back of head. The patient's sister called the attending physician and informed him the patient had low blood pressure and was falling, and would be late to the appointment. The sister indicated the office staff told her this was fine. The RN retook the</p>			

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	<p>patient's blood pressure and it was 68/50. The RN indicated they could not allow the patient to leave with the sister with the patient's blood pressure that low. The RN indicated an ambulance needed to be called before they could allow the patient to leave. The patient indicated they did not want the paramedics called and would not go to the hospital. The patient indicated they wanted to go see the primary care physician] and again tried to stand up and began to pass out. The patient's sister's daughter then dialed 911 and handed the phone to the RN. The RN instructed the paramedics to come to the patient's residence. Upon arrival of the paramedics, the patient's sitting and standing blood pressure was taken. The paramedics stated the patient's standing blood pressure was 70/30 and instructed the patient they needed to go to the hospital. The patient again refused. The patient stated "I have been to the ER the past 3 days and they do nothing for me, I want to see my own doctor." The paramedics had the patient sign a refusal consent and then proceeded to push the patient out to the sister's car in a wheelchair. The patient and the sister then left to go the the patient's doctor appointment with the primary care physician.</p>			

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	<p>C. A skilled nursing visit note dated 7/16/2012 stated, "Routine F/U assess VS [follow up, vital signs] upon assessment pt [patient] hypotensive et [and] reported per self freq [frequency] falls. "Stated I fell 10 times yesterday. I have a Dr. appt [appointment] today. When family attempted to ambulate out of home pt had syncope episode 911 called et assessed by EMS was hypotensive refused to go to hospital did agree to go in family car to Dr. appt for evaluation et treatment. Will f/u with PCP [Primary Care Physician] et mother for pt status after visit today."</p> <p>D. On 7/17/12 at 9:40 AM, employee A entered the conference room and informed surveyor that they called patient #2 last night to follow up and patient #2 indicated they were being admitted to Methodist Hospital. When asked if employee A followed-up with the physician, employee A indicated they had not done this yet.</p>			

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N0550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on policy review and clinical record review, the home health agency failed to ensure the registered nurse updated the home health aide care plan every 60 days in 1 of 2 records reviewed of patients receiving home health aide services with the potential to affect all of the agency's patients. (#1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Home Health Aide Plan of Care" policy number 4-006.1 states, "The home health aide plan of care will be revised at least every 60 days based upon a professional reassessment of the patient and at any time the patient's change of condition warrants revision." Clinical record #1, start of care 5/15/12, evidenced employee A, RN/ADON, completed a reassessment on patient #1 on 7/6/2012. The record 	N0550	0550RN will update home health aide plan of care every 60 days or with any change in a patient's home health aide plan of care. The assigned nurse to a homehealth aide plan of care will update the home health aide plan of care every 60 days and or with any change a patient's home health aide plan of care. The Director of Nursing will be responsible for promptly and properly orientating and educating each nurse employed with the home health agency on updating the homehealth aide patient plan of care of every 60 days and with any changes to the homehealth aide plan of care.	07/31/2012			

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	<p>failed to evidence a new Home Health Certification and Plan of Care was developed following the 60 day reassessment. The last Home Health Certification and Plan of Care was for the certification period from 5/15/12 to 7/3/12. The record also failed to evidence a new HHA Care plan was developed following the 60 day reassessment. The last HHA Care plan was for the certification period from 5/15/12 to 7/3/12.</p>			

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N0604	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure the home health aide reported any changes observed in the patient's conditions and needs to the supervisory nurse in 1 of 2 records reviewed of patients receiving home health aide services with the potential to affect all of the agency's patients receiving home health aide services. (#1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The job description titled "Certified Home Health Aide", dated June 2011 states, "Reporting on patient's condition and significant changes to the assigned nurse." 2. Clinical record #1, start of care 5/15/12, included a Home Health Certification and Plan of Care for the Certification Period from 5/15/11 to 7/3/11 with orders that state, "HHA [Home Health Aide] 2-3x/wk x 8 wks" [2-3 times per week times 8 weeks]. The HHA Care Plan states to "Notify Nurse: ... 	N0604	<p>0604Nurse will enforce and educate the home health aide on when, what and why need to report and significant change in a patient's conditon via in witting and verbally to the assigned nurse.The assigned nurse to the home health aide will enforce there assigned home health aide properly report any significant change in a patient's conditon via witting and verbally to the assigned nurse.The Director of Nursing will be responsible for proper orientating and educating each nurse and home health aide employed by the homehealth agency of proper communication to the assigned nurse of a change in a patinet's contion via written and verbally.</p>	07/31/2012	

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	<p>B/P [blood pressure] >180/100 <90/50."</p> <p>A. A HHA Progress Note dated 6/18/12, signed by employee E, HHA, states, "complaints of burning when urinating - red gauld on rt [right] breast and rt groin and abd [abdominal] fold and apron. Resident contacted MD [Medical Doctor]."</p> <p>B. A HHA Progress Note dated 6/27/12, signed by Employee E, HHA, states, "B/P [blood pressure] 90/48."</p> <p>C. On 7/17/12 at 11:35 AM, employee A, RN/ADON, indicated the HHA did not report these findings to the RN.</p>			

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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on policy review, document review, clinical record review, and interview, the home health agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days as required by agency policy in 2 of 2 records reviewed of patients receiving home health aide services with the potential to affect all of the agency's patients who receive home health aide services. (#1 and #4)</p> <p>Findings include:</p> <p>1. Facility policy titled "Home Health Aide Plan of Care", policy number 4-006.1 states, "The case manager or another appropriate clinician will supervise the home health aide at least every 14 days to ensure care is provided according to plan."</p> <p>2. Facility policy titled "Continuity of</p>	N0606	0606RN will observe the home health aide in each patient's home every 14 days, as required by the home health agency policy. The assigned nurse to the homehealth aide will do supervised home health aide visit every 14 days and as needed. The Director of Nursing will be responsible for over seeing that the assigned nurse to the home health aide is doing a supervised visit with the home health aide every 14 days and as needed. The Director of Nursing will also be responsible for supervised home health visit of each nurse every 14 days and as needed.	07/31/2012			

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	<p>Care", policy number 4-010.1 states, "The clinician will be responsible for scheduling and conducting home health supervisory visits."</p> <p>3. The job description titled "Registered Nurse (RN)" dated June 2011 states, "Instructs, supervises and evaluates home health aide care plan provided every two (2) weeks."</p> <p>4. Clinical record #1, with a start of care date of 5/15/2012, evidenced the patient received HHA services 2-3 times/week for 8 weeks. The HHA services began on 5/21/2012 and the first supervisory visit was not completed until 7/6/2012, more than 14 days after the first HHA visit was initiated.</p> <p>5. Clinical record #4, with a start of care date of 4/24/2012, evidenced the patient received HHA services 2-3 times/week for 9 weeks. Review of the clinical record failed to evidence any supervisory visits have been completed since the start of care.</p> <p>6. On 7/17/12 at 11:28 AM, employee A, RN/ADON, indicated HHA supervisory visits were not being done every 14 days.</p>			

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