

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802
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G000000	<p>This was a revisit for an extended home health federal recertification survey conducted June 2 - 6, 2014.</p> <p>Survey Date: 7/21/14</p> <p>Facility # 005865</p> <p>Medicaid Vendor #: 200237950</p> <p>Surveyor: Shannon Pietraszewski, RN, PH Nurse Surveyor</p> <p>Census: 86</p> <p>During this survey, two conditions and eleven (11) standard level deficiencies were corrected, eight standard level deficiencies were recited, and two new standard level deficiencies were cited.</p> <p>Nurse Care Inc. continues to be precluded from providing home health aide training and competency evaluation for a period of two (2) years beginning June 6, 2014, due to being out of compliance with the Condition of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision and 484.30: Skilled Nursing Services.</p>	G000000		
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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>Quality Review: Joyce Elder, MSN, BSN, RN July 25, 2014</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with the hospital discharge planner for 2 of 2 records reviewed (# 1 and 6) of patients who were hospitalized creating the potential to affect all of the agency's patients that are hospitalized.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/07, included a plan of care</p>	G000143	<p>1. Hospital discharge paperwork was obtained for both records reviewed. 2. Upon notification of hospitalization of a client, the appropriate discharge planner will be contacted. The discharge planner will be informed that we provide home care services for the client and we will need to be notified of discharge and any paperwork relating to the discharge. When feasible, the RN resuming the patient will have the paperwork before going to the client's home. If the client fails to notify the agency of their hospitalization, we will obtain the</p>	08/18/2014			

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	<p>established by the physician for certification period 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The clinical record evidenced the patient was hospitalized from 07/09/14 to 07/16/14. Services were resumed on 07/16/14.</p> <p>b. Employee E, a Registered Nurse / Case Manager, indicated on 07/21/14 at 2:00 PM the patient was not able to locate the discharge paperwork from the hospital and she did not contact the hospital for the paperwork.</p> <p>c. The Director of Nursing notified the hospital and received the information within 15 minutes of the call. The patient was newly diagnosed with cirrhosis of the liver and had approximately 7 liters of fluid removed from his/her abdomen.</p> <p>d. Discharge instruction indicated a change in the patient's diet, monitor weight daily, and monitor for any distention and fluid retention in the abdomen. The clinical record failed to evidence hospital discharge paperwork.</p> <p>2. Clinical record number 6, SOC</p>		<p>paperwork upon knowledge of admission. Daily calls will be made to hospitals to verify if client is still an inpatient. RNs, office staff, and on call staff will be inserviced. A letter will be sent to clients informing them of the need to notify the agency of hospitalizations when they occur.</p> <p>3. The Receptionist and On-Call staff will be responsible for daily calls to the hospital and notifying the DON/ADON upon discharge. DON/ADON will assure that discharge paperwork from the hospital will be in the clinical record and verify any changes or new orders are implemented. A Client Status Report will circulate through the office during normal working days to inform of changes</p> <p>4. 8/18/2014</p>				

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	<p>11/25/13, included a plan of care established by the physician for the certification period 05/24/14 to 07/22/14 with orders for skilled nursing up to 68 - 192 hours a month through Medicaid Waiver.</p> <p>a. The clinical record evidenced the patient returned home on 07/01/14 from being hospitalized for a diagnosis of "high sodium". Services were resumed on 07/02/14.</p> <p>b. Employee E, a Registered Nurse / Case Manager, indicated on 07/21/14 at 2:00 PM the patient's mother was not able to locate the discharge paperwork from the hospital and she did not contact the hospital for the paperwork.</p> <p>c. The clinical record failed to evidence hospital discharge paperwork.</p> <p>3. An undated policy titled "Coordination of Client Care" stated, "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will</p>			

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G000144	<p>maintain liaison to ensure that their efforts are coordinated effectively."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with the hospital discharge planner for 2 of 2 records reviewed (# 1 and 6) of patients who were hospitalized creating the potential to affect all of the agency's patients that are hospitalized.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/07, included a plan of care established by the physician for</p>	G000144	<p>1. Hospital discharge paperwork was obtained for both records reviewed. 2. Upon notification of hospitalization of a client, the appropriate discharge planner will be contacted. The discharge planner will be informed that we provide home care services for the client and we will need to be notified of discharge and any paperwork relating to the discharge. When feasible, the RN resuming the patient will have the paperwork before going to the client's home. If the client fails to notify the agency of their hospitalization, we will obtain the paperwork upon knowledge of</p>	08/18/2014	

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	<p>certification period 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The clinical record evidenced the patient was hospitalized from 07/09/14 to 07/16/14. Services were resumed on 07/16/14.</p> <p>b. Employee E, a Registered Nurse / Case Manager, indicated on 07/21/14 at 2:00 PM the patient was not able to locate the discharge paperwork from the hospital and she did not contact the hospital for the paperwork.</p> <p>c. The Director of Nursing notified the hospital and received the information within 15 minutes of the call. The patient was newly diagnosed with cirrhosis of the liver and had approximately 7 liters of fluid removed from his/her abdomen.</p> <p>d. Discharge instruction indicated a change in the patient's diet, monitor weight daily, and monitor for any distention and fluid retention in the abdomen. The clinical record failed to evidence hospital discharge paperwork.</p> <p>2. Clinical record number 6, SOC 11/25/13, included a plan of care</p>		<p>admission. Daily calls will be made to hospitals to verify if client is still an inpatient. RNs, office staff, and on call staff will be inserviced. A letter will be sent to clients informing them of the need to notify the agency of hospitalizations when they occur.</p> <p>3. The Receptionist and On-Call staff will be responsible for daily calls to the hospital and notifying the DON/ADON upon discharge. DON/ADON will assure that discharge paperwork from the hospital will be in the clinical record and verify any changes or new orders are implemented. A Client Status Report will circulate through the office during normal working days to inform of changes. 4. 8/18/2014</p>		

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	<p>established by the physician for the certification period 05/24/14 to 07/22/14 with orders for skilled nursing up to 68 - 192 hours a month through Medicaid Waiver.</p> <p>a. The clinical record evidenced the patient returned home on 07/01/14 from being hospitalized for a diagnosis of "high sodium". Services were resumed on 07/02/14.</p> <p>b. Employee E, a Registered Nurse / Case Manager, indicated on 07/21/14 at 2:00 PM the patient's mother was not able to locate the discharge paperwork from the hospital and she did not contact the hospital for the paperwork.</p> <p>c. The clinical record failed to evidence hospital discharge paperwork.</p> <p>3. An undated policy titled "Coordination of Client Care" stated, "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will maintain liaison to ensure that their</p>			

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G000159	<p>efforts are coordinated effectively."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure written plans of care were revised and updated in relation to specific duties for home health aides, medications, durable medical equipment (DME), and wound treatments for 3 of 3 records reviewed creating the potential to affect all patients receiving wound care services and home health aide services within the agency. (# 1, 6, and 8)</p> <p>Findings include:</p> <p>1. Clinical record number 1 included a</p>	G000159	<p>1. The 3 records reviewed have been corrected either by a verbal order or amended/new 485. Others will be corrected when a new 485 is generated from a recertification, or a verbal order will be obtained if the recert is after completion date. 2. HHA/ATTC assignment sheets have been updated to be more specific in care. Briggs forms 3546P, 3428P, 3491P-10, and 3492P-10 have been ordered, obtained, and are now being distributed to the RNs to use on admission and recertification. The forms specify DME and supplies used in the home for the 485. 3. DON/ADON will be</p>	08/18/2014

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	<p>plan of care established by the physician for certification period 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care also included the attendant care was to assist with activities of daily living, light housekeeping, meal prep, and errands as needed. The plan of care failed to be specific in the bathing, grooming, and activities of daily living tasks.</p> <p>b. During a home visit with the patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week via a permacath. The patient indicated the permacath was removed approximately a month ago. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week and had his / her permacath removed on 05/12/14. The plan of care failed to evidence that the patient was receiving dialysis 3 times a week, maintenance of the permacath, and medications received during dialysis treatments.</p>		responsible to review all paperwork from nurses to assure that all DME/equipment and specific orders are on the 485. 4. 8/18/2014				

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	<p>c. The home was observed to have a Hoyer lift in the home and a life line alert. The plan of care failed to evidence the Hoyer lift and the life line alert under DME / supplies section.</p> <p>d. The plan of care stated the patient wore TED hose. The patient indicated on 06/03/14 at 9:00 AM he/she had not worn TED hose for a long time due to the stockings leaving indentations around his/her ankles.</p> <p>e. The plan of care stated the patient was a diabetic and received insulin. The plan of care failed to evidence diabetic supplies used under the DME / supplies section.</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period 05/24/14 to 07/22/14 with orders for skilled nursing services to assist the patient with any personal care needs, ulcer care when ordered, assess skin, tube feedings, suctioning as needed, med set-up and administer, and monitoring vital signs. The DME / Supplies stated the patient was receiving ileostomy supplies.</p> <p>a. The daily nursing notes evidenced the patient had a g-tube and was</p>				

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	<p>receiving care to the area. The plan of care failed to include treatment instructions for the g-tube care.</p> <p>b. The daily nursing notes evidenced the patient had an ileostomy and was receiving care to the area. The plan of care failed to include treatment instructions and size and type of appliance to be applied to the patient's ostomy site.</p> <p>c. The plan of care stated the patient was to have silvadene cream topical as needed and duoderm every week and as needed. The plan of care failed to evidence specific instructions for use of the silvadene creme and duoderm.</p> <p>3. Clinical record number 8, start of care 01/29/13, included a plan of care established by the physician for certification period 07/11/14 to 09/09/14. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living tasks.</p> <p>4. An undated policy titled "Care Planning" stated, "Modifications of the planned care based on reassessment of</p>						

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G000165	<p>the patient / client's continual need for care or services ... The plan of care, developed in accordance with the referring physician's orders, shall include, but not limited to ... services to be provided at what intervals, and by whom, medical equipment and supplies, medications ... The admitting RN will initiate the written Plan of Care at the start of care, and the plan will be updated at least every sixty [60] days or as needed."</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 medications were administered by the skilled nurse as ordered by the physician for 1 of 1 records reviewed of patients with medication administration creating the potential to affect all patients who received medications by a skilled nurse. (# 6)</p>	G000165	<p>1. Nurses will be inserviced on updating MARS with new orders. All MARS will be checked against current orders and updated as needed. 2. Paperwork will be reviewed continuously and MAR will be updated as needed. MARS to be reconciled with 485 at least every 60 days with recertification. MARS to be updated upon receiving any new orders. 3. DON/ADON will be responsible to monitor MARS and</p>	08/18/2014			

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6, included a plan of care established by the physician for the certification period of 05/24/14 to 07/22/14. The plan of care and medication profile indicated that the patient was to receive Acidophilis 1 tab four (4) times a day with g/tube (gastrostomy tube) feedings. <p>The Medication Administration Record failed to evidence Acidophilis was given with g/tube feedings on 07/03/14, 07/07/14, and 07/10/14.</p> <ol style="list-style-type: none"> 2. Employee E indicated on 07/21/14 at 2:00 PM the Medication Administration Record should had been revised to include the Acidophilis. 3. An undated policy titled "Physician Orders / Plan of Care [POC]" stated, "The Agency's professional staff continuously reviews clinical records to determine adequacy of the plan of treatment and appropriateness of the continuation of care. The Agency's professional staff will review the clinical records on a continuous basis to ensure that each POC is specific to the client and that additional orders for services are present in the clinical record ... " 		update as needed. 4. 8/18/2014				

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G000172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse re-evaluated a patient after the patient's return home from a hospitalization within 48 hours in 1 of 2 records reviewed of patients who had been hospitalized and completed the comprehensive assessment prior to creating the plan of care for 2 of 3 records reviewed creating the potential to affect all patients who are hospitalized or who receive services more than 60 days. (# 1 and 6)</p> <p>Findings include:</p> <p>Related to assessment after hospitalization</p> <p>1. Clinical record number 1, start of care 11/01/07, included a plan of care established by the physician for the certification period 05/29/14 to 07/27/14 with orders for monthly registered nurse</p>	G000172	<p>1. The 2 records reviewed had a comprehensive assessment within the 5 day window and the 485 was amended with that assessment. 2. Nurses have a new recertification schedule to assure that a comprehensive assessment (Briggs forms 3492P-10 and 3428P) is completed in the 5 day window. Nurses also have an Update Comprehensive Assessment (Briggs form 3427P) to complete on a resumption of care. 3. DON/ADON will be responsible for tracking that the assessments are completed and scheduling the nurses for the recerts/resumes. 4. 8/18/2014</p>	08/18/2014

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	<p>supervision, home health aide services 2 hours a day for 7 days a week, and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>A. The clinical record evidenced the patient was hospitalized from 07/09/14 to 07/16/14. Services were resumed on 07/16/14. The record failed to evidence an assessment to reevaluate the patient's needs had been completed within 48 hours after the hospitalization.</p> <p>B. Employee E, a Registered Nurse, indicated on 07/21/14 at 2:00 PM she did not do a comprehensive assessment after the patient returned from the hospital.</p> <p>C. An undated policy titled "OASIS Assessment of Clients" stated, "A Resumption of Care assessment will be completed within 48 hours [or knowledge of] on every client following a hospital stay of 24 hours or more for any reason other than diagnostic tests."</p> <p>Related to creating the plan of care before completing the comprehensive assessment</p> <p>2. Clinical record number 1, start of care 11/01/07, included a plan of care established by the physician for</p>			

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NAME OF PROVIDER OR SUPPLIER NURSE CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 790 E MARLEY DR TERRE HAUTE, IN 47802			
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G000176	<p>certification period 05/29/14 to 07/27/14 and a plan of care dated 07/28/14 (today's date is 7/22/14) to 09/26/14. The record failed to evidence the comprehensive recertification had be completed prior to the establishment of the new plan of care.</p> <p>3. Clinical record number 6 included a plan of care established by the physician for the certification period 05/24/14 to 07/22/14 and a plan of care dated 07/23/14 to 09/20/14. The record failed to evidence the recertification comprehensive assessment had been completed prior to the establishment of the new plan of care.</p> <p>4. Employee E indicated on 07/21/14 at 2:00 PM the comprehensive assessments had not been completed to establish the new plan of care.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record and policy review and interview, the agency failed to ensure the Registered nurse coordinated</p>	G000176	1. Hospital discharge paperwork was obtained for both records reviewed. 2. Upon notification of hospitalization of a client, the	08/18/2014			

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	<p>effectively with the hospital discharge planner for 2 of 2 records reviewed of patients that were hospitalized (# 1 and 6) creating the potential to affect all of the agency's patients that receive services from more than one provider.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/07, included a plan of care established by the physician for certification period 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The clinical record evidenced the patient was hospitalized from 07/09/14 to 07/16/14. Services were resumed on 07/16/14.</p> <p>b. Employee E, a Registered Nurse / Case Manager, indicated on 07/21/14 at 2:00 PM the patient was not able to locate the discharge paperwork from the hospital and she did not contact the hospital for the paperwork.</p> <p>c. The Director of Nursing notified the hospital and received the information within 15 minutes of the call. The patient was newly diagnosed with cirrhosis of</p>		<p>appropriate discharge planner will be contacted. The discharge planner will be informed that we provide home care services for the client and we will need to be notified of discharge and any paperwork relating to the discharge. When feasible, the RN resuming the patient will have the paperwork before going to the client's home. If the client fails to notify the agency of their hospitalization, we will obtain the paperwork upon knowledge of admission. Daily calls will be made to hospitals to verify if client is still an inpatient. RNs, office staff, and on call staff will be inserviced. A letter will be sent to clients informing them of the need to notify the agency of hospitalizations when they occur.</p> <p>3. The Receptionist and On-Call staff will be responsible for daily calls to the hospital and notifying the DON/ADON upon discharge. DON/ADON will assure that discharge paperwork from the hospital will be in the clinical record and verify any changes or new orders are implemented. A Client Status Report will circulate through the office during normal working days to inform of changes 4. 8/18/2014</p>				

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	<p>the liver and had approximately 7 liters of fluid removed from his/her abdomen.</p> <p>d. Discharge instruction indicated a change in the patient's diet, monitor weight daily, and monitor for any distention and fluid retention in the abdomen. The clinical record failed to evidence hospital discharge paperwork.</p> <p>2. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 05/24/14 to 07/22/14 with orders for skilled nursing up to 68 - 192 hours a month through Medicaid Waiver.</p> <p>a. The clinical record evidenced the patient returned home on 07/01/14 from being hospitalized for a diagnosis of "high sodium". Services were resumed on 07/02/14.</p> <p>b. Employee E, a Registered Nurse / Case Manager, indicated on 07/21/14 at 2:00 PM the patient's mother was not able to locate the discharge paperwork from the hospital and she did not contact the hospital for the paperwork.</p> <p>c. The clinical record failed to evidence hospital discharge paperwork.</p>						

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G000207	<p>3. An undated policy titled "Coordination of Client Care" stated, "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will maintain liaison to ensure that their efforts are coordinated effectively."</p> <p>484.36(a)(2) HHA TRAINING - CONDUCT A home health aide training program may be offered by any organization except an HHA that, within the previous two years, has been found:</p> <ul style="list-style-type: none"> - Out of compliance with requirements of this paragraph (a) or paragraph (b) of this section - To permit an individual that does not meet the definition of "home health aide" as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers) - Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State) - Has been assessed a civil monetary 			

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	<p>penalty of not less than \$5,000 as an intermediate sanction</p> <ul style="list-style-type: none"> - Has been found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee the management of the HHA - Has had all or part of its Medicare payments suspended <p>Further, under any Federal or State law within the 2-year period beginning on October 1, 1988:</p> <ul style="list-style-type: none"> - Has had its participation in the Medicare program terminated - Has been assessed a penalty of not less than \$5,000 for deficiencies in Federal or State standards for HHAs - Was subject to a suspension of Medicare payments to which it otherwise would have been entitled; - Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients - Was closed or had its residents transferred by the State. <p>Based on personnel record review and interview, the agency failed to ensure Home Health Aide (HHA) competency testing was not performed by the agency while precluded for 4 of 4 HHAs hired since the beginning of the preclusion with the potential to affect all the HHA services provided by the agency. (I, J, K, and L)</p> <p>Findings include:</p>	G000207	<ol style="list-style-type: none"> 1. Employees affected were taken off the schedule. A letter was sent to the Aide Registry to notify them that we performed competency testing while we were precluded from doing so. 2. Only contracted staff will be used for competency testing for the two year period. 3. DON and Administrator will be responsible for obtaining and using contracted staff. 4. 8/1/2014 	08/01/2014	

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	<p>1. Nurse Care Inc. was precluded from providing home health aide training and competency evaluation for a period of two (2) years beginning June 6, 2014, due to being out of compliance with the Condition of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision and 484.30: Skilled Nursing Services on the recertification survey completed 6/6/14.</p> <p>2. Personnel record I, a home health aide (HHA), start date 06/17/14, evidenced an aide skills competency check list that identified the employee was checked off on 06/20/14 by Employee F, an agency employee. The state aide registry indicated Employee I was placed on the registry on 06/20/14.</p> <p>3. Personnel record J, a HHA, start date 06/17/14, evidenced an aide skills competency check list that identified the employee was checked off on 06/18/14 by Employee F, an employee of the agency. The state aide registry identified Employee J's status on the registry was "expired license renewal."</p> <p>4. Personnel record K, a HHA, start date 06/17/14, evidenced an aide skills competency check list that identified the employee was checked off on 06/19/14 by Employee F, an agency employee.</p>			

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G000337	<p>The state aide registry indicated Employee I was placed on the registry on 06/19/14.</p> <p>5. Personnel record L, a HHA, start date 06/26/14, evidenced an aide skills competency check list that identified the employee was checked off on 06/20/14 by Employee F, an agency employee. The state aide registry indicated Employee I was placed on the registry on 07/01/14.</p> <p>6. Employee M, human resources, indicated on 07/21/14 at 2:50 PM she was told by the Director of Nursing it was ok for the staff to do competencies.</p> <p>7. The Director of Nursing indicated on 07/21/14 at 2:55 PM she had contacted the Indiana State Department of Health and was informed that it was ok for the agency to do their competencies. The Director of Nursing indicated she could not remember who she had spoken with but it was the "person in charge."</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the</p>						

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	<p>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 medications that had been changed during a hospitalization had been ordered by the physician and changed /reconciled on the medication profile upon discharge from the hospital for 1 of 2 records reviewed of patients who were hospitalized creating the potential to affect all patients who are hospitalized. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record number 1, start of care 11/01/07, included a Medication Profile last updated on 07/14/14 by the Director of Nursing. The medication profile indicated the patient was taking Humalog 4 Units subcutaneously with meals, Prevacid 30 milligrams (mg) daily, Synthroid 100 micrograms daily, Reglan 5 mg four (4) times a day, Savella 50 mg two (2) times a day, Zofran 4 mg as needed, APAP 500 mg four (4) times a day, Xanax 0.5 mg three (3) times a day as needed, Ambien 5 mg at bedtime, Humalog sliding scale subcutaneously as needed for blood sugars greater than 149,</p>	G000337	<p>1. Hospital discharge paperwork was obtained for both records reviewed. 2. Upon notification of hospitalization of a client, the appropriate discharge planner will be contacted. The discharge planner will be informed that we provide home care services for the client and we will need to be notified of discharge and any paperwork relating to the discharge. When feasible, the RN resuming the patient will have the paperwork before going to the client's home. If the client fails to notify the agency of their hospitalization, we will obtain the paperwork upon knowledge of admission. Daily calls will be made to hospitals to verify if client is still an inpatient. RNs, office staff, and on call staff will be inserviced. A letter will be sent to clients informing them of the need to notify the agency of hospitalizations when they occur. RN will reconcile medications upon resumption. 3. The Receptionist and On-Call staff will be responsible for daily calls to the hospital and notifying the DON/ADON upon discharge. DON/ADON will assure that discharge paperwork from the hospital will be in the clinical record and verify any changes or</p>	08/18/2014

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	<p>Levemir 15 Units subcutaneously daily, Vitamin D3 1000 Units three (3) tabs twice (2) a day, and Magnesium 400 mg daily.</p> <p>The patient was discharged from the hospital on 07/15/14 with orders for Levemir 15 Units subcutaneously daily at bedtime, Prevacid 30 mg daily, Synthroid 100 mcg daily every morning, Magnesium Oxide 250 mg daily, Reglan 5 mg twice (2) a day before meals and at bedtime, Savella 59 mg twice a day, Mirapex 0.25 mg daily at bedtime, Ambien 5 mg daily at bedtime, Allopurinol 100 mg daily, and Humalog sliding scale coverage before meals and at bedtime 71 - 100 = 0 Units; 11 - 149 = 2 Units; 150 - 199 = 3 Units; 200 - 249 4 Units; 250 - 299 5 Units; 300 - 349 6 Units; 350 - 399 = 7 Units; greater than 400 10 Units and notify the physician. The clinical record failed to evidence the medications had been ordered by the physician and changed /reconciled on the medication profile.</p> <p>2. Employee E indicated on 07/21/14 at 2:00 PM that she did not obtained a copy of the hospital discharge paperwork to reconcile medications with the primary care physician.</p>		new orders are implemented. A Client Status Report will circulate through the office during normal working days to inform of changes 4. 8/18/2014		

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G000340	<p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse completed a Resumption of Care assessment within 48 hours of patient's return home (or knowledge of) from a hospitalization in 1 of 2 records reviewed of patients who had been hospitalized creating the potential to affect all patients who are hospitalized. (# 1)</p> <p>Findings include:</p> <p>1. Clinical record number 1, start of care 11/01/07, included a plan of care established by the physician for the certification period 05/29/14 to 07/27/14 with orders for monthly registered nurse supervision, home health aide services 2 hours a day for 7 days a week, and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>The clinical record evidenced the patient was hospitalized from 07/09/14 to 07/16/14. Services were resumed on 07/16/14. The record failed to evidence a</p>	G000340	<p>1. The 2 records reviewed had a comprehensive assessment within the 5 day window and the 485 was amended with that assessment. 2. Nurses have a new recertification schedule to assure that a comprehensive assessment (Briggs forms 3492P-10 and 3428P) is completed in the 5 day window. Nurses also have an Update Comprehensive Assessment (Briggs form 3427P) to complete on a resumption of care. 3. DON/ADON will be responsible for tracking that the assessments are completed and scheduling the nurses for the recerts/resumes. 4. 8/18/2014</p>	08/18/2014

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N000000	<p>resumption of care n assessment had been completed within 48 hours after the patient's return home from a hospitalization.</p> <p>2. Employee E, a Registered Nurse, indicated on 07/21/14 at 2:00 PM she did not do a comprehensive assessment after the patient returned from the hospital.</p> <p>3. An undated policy titled "OASIS Assessment of Clients" stated "A Resumption of Care assessment will be completed within 48 hours [or knowledge of] on every client following a hospital stay of 24 hours or more for any reason other than diagnostic tests."</p> <p>This was a revisit for a home health relicensure survey conducted June 2 - 6, 2014.</p> <p>Survey Date: 7/21/14</p> <p>Facility # 005865</p>	N000000			

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N000486	<p>Medicaid Vendor #: 200237950</p> <p>Surveyor: Shannon Pietraszewski, RN, PH Nurse Surveyor</p> <p>Census: 86</p> <p>During this survey, nine deficiencies were corrected and five deficiencies were recited.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 25, 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.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with the hospital discharge planner for 2 of 2 records reviewed (# 1 and 6) of patients who were hospitalized creating the potential to affect all of the agency's patients that are hospitalized.</p>	N000486	<p>1. Hospital discharge paperwork was obtained for both records reviewed. 2. Upon notification of hospitalization of a client, the appropriate discharge planner will be contacted. The discharge planner will be informed that we provide home care services for the client and we will need to be notified of discharge and any paperwork relating to the discharge. When feasible, the</p>	08/18/2014

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	<p>distention and fluid retention in the abdomen. The clinical record failed to evidence hospital discharge paperwork.</p> <p>2. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 05/24/14 to 07/22/14 with orders for skilled nursing up to 68 - 192 hours a month through Medicaid Waiver.</p> <p>a. The clinical record evidenced the patient returned home on 07/01/14 from being hospitalized for a diagnosis of "high sodium". Services were resumed on 07/02/14.</p> <p>b. Employee E, a Registered Nurse / Case Manager, indicated on 07/21/14 at 2:00 PM the patient's mother was not able to locate the discharge paperwork from the hospital and she did not contact the hospital for the paperwork.</p> <p>c. The clinical record failed to evidence hospital discharge paperwork.</p> <p>3. An undated policy titled "Coordination of Client Care" stated, "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be</p>						

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N000524	<p>documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will maintain liaison to ensure that their efforts are coordinated effectively."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record and policy</p>	N000524	1. The 3 records reviewed have been corrected either by a verbal	08/18/2014			

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	<p>review and interview, the agency failed to ensure written plans of care were revised and updated in relation to specific duties for home health aides, medications, durable medical equipment (DME), and wound treatments for 3 of 3 records reviewed creating the potential to affect all patients receiving wound care services and home health aide services within the agency. (# 1, 6, and 8)</p> <p>Findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for certification period 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care also included the attendant care was to assist with activities of daily living, light housekeeping, meal prep, and errands as needed. The plan of care failed to be specific in the bathing, grooming, and activities of daily living tasks.</p> <p>b. During a home visit with the</p>		<p>order or amended/new 485. Others will be corrected when a new 485 is generated from a recertification, or a verbal order will be obtained if the recert is after completion date. 2. HHA/ATTC assignment sheets have been updated to be more specific in care. Briggs forms 3546P, 3428P, 3491P-10, and 3492P-10 have been ordered, obtained, and are now being distributed to the RNs to use on admission and recertification. The forms specify DME and supplies used in the home for the 485. 3. DON/ADON will be responsible to review all paperwork from nurses to assure that all DME/equipment and specific orders are on the 485. 4. 8/18/2014</p>	

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	<p>patient on 06/03/14 at 9:00 AM, the patient indicated he / she was receiving dialysis treatments 3 times a week via a permacath. The patient indicated the permacath was removed approximately a month ago. The clinical record evidenced the patient was receiving dialysis treatments 3 times a week and had his / her permacath removed on 05/12/14. The plan of care failed to evidence that the patient was receiving dialysis 3 times a week, maintenance of the permacath, and medications received during dialysis treatments.</p> <p>c. The home was observed to have a Hoyer lift in the home and a life line alert. The plan of care failed to evidence the Hoyer lift and the life line alert under DME / supplies section.</p> <p>d. The plan of care stated the patient wore TED hose. The patient indicated on 06/03/14 at 9:00 AM he/she had not worn TED hose for a long time due to the stockings leaving indentations around his/her ankles.</p> <p>e. The plan of care stated the patient was a diabetic and received insulin. The plan of care failed to evidence diabetic supplies used under the DME / supplies section.</p>			

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	<p>2. Clinical record number 6 included a plan of care established by the physician for the certification period 05/24/14 to 07/22/14 with orders for skilled nursing services to assist the patient with any personal care needs, ulcer care when ordered, assess skin, tube feedings, suctioning as needed, med set-up and administer, and monitoring vital signs. The DME / Supplies stated the patient was receiving ileostomy supplies.</p> <p>a. The daily nursing notes evidenced the patient had a g-tube and was receiving care to the area. The plan of care failed to include treatment instructions for the g-tube care.</p> <p>b. The daily nursing notes evidenced the patient had an ileostomy and was receiving care to the area. The plan of care failed to include treatment instructions and size and type of appliance to be applied to the patient's ostomy site.</p> <p>c. The plan of care stated the patient was to have silvadene cream topical as needed and duoderm every week and as needed. The plan of care failed to evidence specific instructions for use of the silvadene creme and duoderm.</p> <p>3. Clinical record number 8, start of care</p>			

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N000537	<p>01/29/13, included a plan of care established by the physician for certification period 07/11/14 to 09/09/14. The plan of care included that the home health aide was to assist with bathing, grooming, activities of daily living, and light housekeeping. The plan of care failed to be specific in the bathing, grooming, and activities of daily living tasks.</p> <p>4. An undated policy titled "Care Planning" stated, "Modifications of the planned care based on reassessment of the patient / client's continual need for care or services ... The plan of care, developed in accordance with the referring physician's orders, shall include, but not limited to ... services to be provided at what intervals, and by whom, medical equipment and supplies, medications ... The admitting RN will initiate the written Plan of Care at the start of care, and the plan will be updated at least every sixty [60] days or as needed."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p>	N000537	1. Nurses will be inserviced on updating MARS with new orders.	08/18/2014			

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	<p>Based on clinical record and policy review and interview, the agency failed to ensure medications were administered by the skilled nurse as ordered by the physician for 1 of 1 records reviewed of patients with medication administration creating the potential to affect all patients who received medications by a skilled nurse. (# 6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record number 6, included a plan of care established by the physician for the certification period of 05/24/14 to 07/22/14. The plan of care and medication profile indicated that the patient was to receive Acidophilis 1 tab four (4) times a day with g/tube (gastrostomy tube) feedings. The Medication Administration Record failed to evidence Acidophilis was given with g/tube feedings on 07/03/14, 07/07/14, and 07/10/14. Employee E indicated on 07/21/14 at 2:00 PM the Medication Administration Record should had been revised to include the Acidophilis. An undated policy titled "Physician Orders / Plan of Care [POC]" stated, "The Agency's professional staff 		<p>All MARS will be checked against current orders and updated as needed. 2. Paperwork will be reviewed continuously and MAR will be updated as needed. MARS to be reconciled with 485 at least every 60 days with recertification. MARS to be updated upon receiving any new orders. 3. DON/ADON will be responsible to monitor MARS and update as needed. 4. 8/18/2014</p>				

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N000541	<p>continuously reviews clinical records to determine adequacy of the plan of treatment and appropriateness of the continuation of care. The Agency's professional staff will review the clinical records on a continuous basis to ensure that each POC is specific to the client and that additional orders for services are present in the clinical record ... "</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse re-evaluated a patient after the patient's return home from a hospitalization within 48 hours in 1 of 2 records reviewed of patients who had been hospitalized and completed the comprehensive assessment prior to creating the plan of care for 2 of 3 records reviewed creating the potential to affect all patients who are hospitalized or who receive services more than 60 days. (# 1 and 6)</p> <p>Findings include:</p>	N000541	<p>1. The 2 records reviewed had a comprehensive assessment within the 5 day window and the 485 was amended with that assessment. 2. Nurses have a new recertification schedule to assure that a comprehensive assessment (Briggs forms 3492P-10 and 3428P) is completed in the 5 day window. Nurses also have an Update Comprehensive Assessment (Briggs form 3427P) to complete on a resumption of care. 3. DON/ADON will be responsible for tracking that the assessments are completed and scheduling the nurses for the recerts/resumes. 4. 8/18/2014</p>	08/18/2014			

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	<p>Related to assessment after hospitalization</p> <p>1. Clinical record number 1, start of care 11/01/07, included a plan of care established by the physician for the certification period 05/29/14 to 07/27/14 with orders for monthly registered nurse supervision, home health aide services 2 hours a day for 7 days a week, and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>A. The clinical record evidenced the patient was hospitalized from 07/09/14 to 07/16/14. Services were resumed on 07/16/14. The record failed to evidence an assessment to reevaluate the patient's needs had been completed within 48 hours after the hospitalization.</p> <p>B. Employee E, a Registered Nurse, indicated on 07/21/14 at 2:00 PM she did not do a comprehensive assessment after the patient returned from the hospital.</p> <p>C. An undated policy titled "OASIS Assessment of Clients" stated, "A Resumption of Care assessment will be completed within 48 hours [or knowledge of] on every client following a hospital stay of 24 hours or more for any reason other than diagnostic tests."</p>			

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N000545	<p>Related to creating the plan of care before completing the comprehensive assessment</p> <p>2. Clinical record number 1, start of care 11/01/07, included a plan of care established by the physician for certification period 05/29/14 to 07/27/14 and a plan of care dated 07/28/14 (today's date is 7/22/14) to 09/26/14. The record failed to evidence the comprehensive recertification had be completed prior to the establishment of the new plan of care.</p> <p>3. Clinical record number 6 included a plan of care established by the physician for the certification period 05/24/14 to 07/22/14 and a plan of care dated 07/23/14 to 09/20/14. The record failed to evidence the recertification comprehensive assessment had been completed prior to the establishment of the new plan of care.</p> <p>4. Employee E indicated on 07/21/14 at 2:00 PM the comprehensive assessments had not been completed to establish the new plan of care.</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where</p>				

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	<p>services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the Registered nurse coordinated effectively with the hospital discharge planner for 2 of 2 records reviewed of patients that were hospitalized (# 1 and 6) creating the potential to affect all of the agency's patients that receive services from more than one provider.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 11/01/07, included a plan of care established by the physician for certification period 05/29/14 to 07/27/14 with orders for home health aide services 2 hours a day for 7 days a week and attendant care services 2 - 6 hours a day for 3 times a week.</p> <p>a. The clinical record evidenced the patient was hospitalized from 07/09/14 to 07/16/14. Services were resumed on 07/16/14.</p> <p>b. Employee E, a Registered Nurse / Case Manager, indicated on 07/21/14 at 2:00 PM the patient was not able to</p>	N000545	<p>1. Hospital discharge paperwork was obtained for both records reviewed. 2. Upon notification of hospitalization of a client, the appropriate discharge planner will be contacted. The discharge planner will be informed that we provide home care services for the client and we will need to be notified of discharge and any paperwork relating to the discharge. When feasible, the RN resuming the patient will have the paperwork before going to the client's home. If the client fails to notify the agency of their hospitalization, we will obtain the paperwork upon knowledge of admission. Daily calls will be made to hospitals to verify if client is still an inpatient. RNs, office staff, and on call staff will be inserviced. A letter will be sent to clients informing them of the need to notify the agency of hospitalizations when they occur. 3. The Receptionist and On-Call staff will be responsible for daily calls to the hospital and notifying the DON/ADON upon discharge. DON/ADON will assure that discharge paperwork from the hospital will be in the clinical record and verify any changes or new orders are implemented. A Client Status Report will circulate through the office during normal</p>	08/18/2014

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	<p>locate the discharge paperwork from the hospital and she did not contact the hospital for the paperwork.</p> <p>c. The Director of Nursing notified the hospital and received the information within 15 minutes of the call. The patient was newly diagnosed with cirrhosis of the liver and had approximately 7 liters of fluid removed from his/her abdomen.</p> <p>d. Discharge instruction indicated a change in the patient's diet, monitor weight daily, and monitor for any distention and fluid retention in the abdomen. The clinical record failed to evidence hospital discharge paperwork.</p> <p>2. Clinical record number 6, SOC 11/25/13, included a plan of care established by the physician for the certification period 05/24/14 to 07/22/14 with orders for skilled nursing up to 68 - 192 hours a month through Medicaid Waiver.</p> <p>a. The clinical record evidenced the patient returned home on 07/01/14 from being hospitalized for a diagnosis of "high sodium". Services were resumed on 07/02/14.</p> <p>b. Employee E, a Registered Nurse / Case Manager, indicated on 07/21/14 at</p>		working days to inform of changes 4. 8/18/2014		

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	<p>2:00 PM the patient's mother was not able to locate the discharge paperwork from the hospital and she did not contact the hospital for the paperwork.</p> <p>c. The clinical record failed to evidence hospital discharge paperwork.</p> <p>3. An undated policy titled "Coordination of Client Care" stated, "All providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, be documented in the client record ... The clinical record will contain appropriate documentation to support steps taken in the process of client care coordination ... All personnel furnishing services will maintain liaison to ensure that their efforts are coordinated effectively."</p>			