

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2015
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NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2013 CHESTER BLVD RICHMOND, IN 47374
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G 000 Bldg. 00	<p>This was an initial Medicaid certification Survey. This was a partial extended survey.</p> <p>Survey dates were March 12, 13, 16, 17, 2015.</p> <p>Facility Number: 013593</p> <p>Surveyor: Michelle Weiss RN MSN</p> <p>Census: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 23, 2015</p>	G 000		
G 159 Bldg. 00	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p>			

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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	<p>Based on clinical record review, observation, and interview, the agency failed to ensure the registered nurse accurately and completely assessed the patient's leg edema in 1 of 10 patient. (#1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1 evidenced the patient had pitting edema of the legs, with more pitting on the right than on the left. SN nursing notes dated 1/28/15 through 3/16/15 consistently failed to evidence the nurse had measured both legs to monitor the progress of the edema. 2. During a home visit on 3/16/15 at 11:11 AM, observation identified the right leg was visibly larger than the left left. The patient indicated he/she had a previous deep vein thrombosis in the right leg. 3. During an interview on 3/17/15 at 10 AM, the Director of Nursing, employee D, stated, "Yes, the right leg was larger than the left. We talked about that on the site visit. It had been like that, it's not new. The nurse, [employee C], opened the case and she had said it had been more swollen when the care began." 	G 159	SN recerted client on 3/19/2015 which included circumference measurements of bilateral lower extremities Clinical staff in-serviced on 3/16/2015 on policy Comprehensive Client Assessment to include measurements of extremities with edema and document each scheduled visit (see policy) Director of Nursing to assign task in schedule for each visit of patients with diagnosis of edema utilizing Kinnser software Monitor QA 100% tasks assigned for measurement for 3 months, then 10% ongoing each quarter	03/31/2015			

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G 172 Bldg. 00	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record, document, and policy review and interview, the agency failed to ensure the plan of care contained accurate medication information for 2 of 10 records reviewed. (# 1 and 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1 evidenced a plan of care for the certification period 1/20/15 - 3/20/15 with the medication Tramadol but failed to evidence the dose that was to be given. 2. Clinical record #9 contained a plan of care for the certification periods 1/23/15 - 3/ 23/15 with the medication Lasix 20 milligrams two times daily. 3, The undated document titled Reid Family Health Center that identified the patient had an appointment on 2/6/15. The document evidenced the patient was to have Lasix, 2 tabs (40 milligrams) twice a day. 4. Agency policy undated "Medication Reconciliation" states, "Documentation of these medications will be listed on the Medication profile and include name, 			G 172	<p>Clinical Record #1 was immediately corrected on medication profile to care plan 3/16/2015 Clinical Record #9 was corrected although patient not active related to transferred to hospital then skilled facility and remained at end of episode 3/23/2015 and discharged audited 100% of charts for accuracy of medication to include name, dose, route of administration, frequency, reconciliation, to plan of care SOC audit tool created to be performed by clinicians at SOC and in-serviced on tool 3/30/2015 to be ongoing Will include medication profile, reconciliation, to plan of care before completed (see form) Director of Nursing to monitor/audit 100% of SOC for 3 months, then 10% each quarter</p>		03/31/2015

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N 000 Bldg. 00	<p>dose, route of administration, frequency and when last dose was taken"...</p> <p>Medications will be reviewed with the client on each home visit to determine if other prescriptions or non-prescription drugs are being taken."</p> <p>5. On 3/17/15 at 6 PM, employee B, registered nurse, stated, "I just wrote the wrong dose."</p>	N 000		
N 524	<p>This was an initial State License Survey. This was a partial extended survey.</p> <p>Survey dates were March 12, 13, 16, 17, 2015.</p> <p>Facility Number: 013593</p> <p>Surveyor: Michelle Weiss RN MSN</p> <p>Census: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 23, 2015</p> <p>410 IAC 17-13-1(a)(1) Patient Care</p>			

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Bldg. 00	<p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record, document, and policy review and interview, the agency failed to ensure the plan of care contained accurate medication information for 2 of 10 records reviewed. (# 1 and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1 evidenced a plan of care for the certification period 1/20/15 - 3/20/15 with the medication Tramadol but failed to evidence the dose that was to be given.</p>	N 524	Clinical Record #1 was immediately corrected on medication profile to care plan 3/16/2015 Clinical Record #9 was corrected although patient not active related to transferred to hospital then skilled facility and remained at end of episode 3/23/2015 and discharged audited 100% of charts for accuracy of medication to include name, dose, route of administration, frequency, reconciliation, to plan of care SOC audit tool created to be performed by clinicians at SOC and in-serviced on tool 3/30/2015	03/31/2015			

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N 541 Bldg. 00	<p>2. Clinical record #9 contained a plan of care for the certification periods 1/23/15 - 3/ 23/15 with the medication Lasix 20 milligrams two times daily.</p> <p>3, The undated document titled Reid Family Health Center that identified the patient had an appointment on 2/6/15. The document evidenced the patient was to have Lasix, 2 tabs (40 milligrams) twice a day.</p> <p>4. Agency policy undated "Medication Reconciliation" states, "Documentation of these medications will be listed on the Medication profile and include name, dose, route of administration, frequency and when last dose was taken"... Medications will be reviewed with the client on each home visit to determine if other prescriptions or non-prescription drugs are being taken."</p> <p>5. On 3/17/15 at 6 PM, employee B, registered nurse, stated, "I just wrote the wrong dose."</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</p>		to be ongoing Will include medication profile, reconciliation, to plan of care before completed (see form) Director of Nursing to monitor/audit 100% of SOC for 3 months, then 10% each quarter				

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	<p>nursing needs.</p> <p>Based on clinical record review, observation, and interview, the agency failed to ensure the registered nurse accurately and completely assessed the patient's leg edema in 1 of 10 patient. (#1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1 evidenced the patient had pitting edema of the legs, with more pitting on the right than on the left. SN nursing notes dated 1/28/15 through 3/16/15 consistently failed to evidence the nurse had measured both legs to monitor the progress of the edema. 2. During a home visit on 3/16/15 at 11:11 AM, observation identified the right leg was visibly larger than the left left. The patient indicated he/she had a previous deep vein thrombosis in the right leg. 3. During an interview on 3/17/15 at 10 AM, the Director of Nursing, employee D, stated, "Yes, the right leg was larger than the left. We talked about that on the site visit. It had been like that, it's not new. The nurse, [employee C], opened the case and she had said it had been more swollen when the care began." 	N 541	<p>SN recerted client on 3/19/2015 which included circumference measurements of bilateral lower extremities Clinical staff in-serviced on 3/16/2015 on policy Comprehensive Client Assessment to include measurements of extremities with edema and document each scheduled visit (see policy) Director of Nursing to assign task in schedule for each visit of patients with diagnosis of edema utilizing Kinnser software Monitor QA 100% tasks assigned for measurement for 3 months, then 10% ongoing each quarter</p>	03/31/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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