

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157652	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/10/2013
NAME OF PROVIDER OR SUPPLIER HOME HEALTH CARE ASSOCIATES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2038 W 2ND STREET MARION, IN 46952		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G000000	<p>This was a home health federal complaint investigation survey.</p> <p>Complaint IN00135903 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey Dates: September 9 and September 10, 2013</p> <p>Facility #: 012169</p> <p>Medicaid #: Not Available</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 13, 2013</p>	G000000			

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

TITLE

(X6) DATE

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

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G000102	<p>484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient was provided a written notice of the patient's rights in advance of furnishing care to the patient during the initial evaluation visit before the initiation of treatment in 1 of 3 patient records reviewed creating the potential to affect all the agency's patients. (#3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #3, start of care 4/6/13, evidenced a document titled "Comprehensive Adult Assessment" dated 4/6/13. The record failed to evidence the patient was provided a written notice of the patient's rights in advance of furnishing care to the patient. 2. On 9/10/13 at 11:20 AM, employee C indicated there was no documentation in the patient's chart to evidence a written notice of the patient's rights was presented during the initial visit on 4/6/13 by the registered nurse. 	G000102	G 0102 DON/or designee will audit 100% of all current client charts to ensure compliance thenDON/ or designee will audit 10% of all current charts weekly until within compliance to ensure they have received a copy of patients rights and that client's chart has an accurate SOC date.DON/or designee will audit every new admission within 72 hours to ensure dated material.DON/or désignée to accompany each case manager on SOC date for verification of knowledge or training with check off.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.	10/09/2013	

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G000143	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 1 of 3 clinical records reviewed creating the potential to affect all the agency's patients. (#3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #3 included a physician's plan of care established for the certification period 8/4 to 10/2/13 with orders for skilled nursing and home health aide services. The record failed to evidence all the services maintained liaison to ensure their efforts were coordinated and supported the plan of care. 2. On 9/9/13 at 12:01 PM, employee C indicated the aide visit frequency for this patient was not communicated between personnel furnishing services. 	G000143	G 0143 The DON has audited 100% of client charts, as of September 20th, 2013 to ensure that hours scheduled are following physician orders and match the Plan of Care. 10% of all client charts will be audited quarterly, by DON/ or designee to ensure Plan of Care and Physician orders are matching hours scheduled. DON/ or designee will audit new admissions within 72 hour to confirm that physician hours ordered matches the client's Plan of Care and are scheduled appropriately. The PA processor and scheduler (all disciplines responsible for scheduling client care) will attend weekly, Monday, nursing meetings to verify any changes noted with any client PA, to ensure compliance in all Any changes made to client schedule will conveyed to HHA/CNAs responsible for patients care, via telephone. Documentation will be noted in clients chart of notification and Case Manager will deliver the updated paperwork to clients home and place in agency folder. administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur	10/09/2013	

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure care care was provided as ordered on the plan of care in 2 of 3 patient records reviewed creating the potential to affect all the agency's patients. (#1 and #3)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 3/5/13, included a plan of care for certification period 7/3 to 8/31/13 with orders for skilled nursing visit frequency 1 time every 2 weeks times 9 weeks for med sets, supervisory visits, and every 60 days for recertification and home health aide visit frequency as 5 hours per day, 4 days per week for 1 week plus 5 hours per day times 7 days per week for 8 weeks. The record failed to evidence home health aide supervisory visits were conducted by the registered nurse from 7/12 to 8/8/13.</p> <p>A. On 9-9-13 at 12:50 PM, employee C indicated there were no supervisory visits conducted by the registered nurse</p>	G000158	G 0158 All skilled caregivers that provide skilled nursing care will be in-serviced on the agency's policy of skilled nursing services by DON/ or designee.DON will mandate an alternate nurse to perform supervisory visit if scheduled nurse is unable to do so. If unable to appoint a nurse to go the DON/ADON will cover the visit.DON/ or designee provided all case managers with a contact list of all other case managers and their telephone numbers to ensure multiple routes of contact. Case managers signed a form stating they received these contact number, and was placed in all of their employee files effective on 9/23/2013.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	10/09/2013			

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	<p>between the dates of July 12 and August 8, 2013.</p> <p>B. The undated agency policy titled "Supervision of Staff" states, "Policy All staff providing home care services will be supervised as outlined by federal and state regulations and accepted standards of practice. ... Special Instructions 1. When clients are receiving skilled nursing services in addition to personal care, the Registered Nurse will make a supervisory visit to the client's residence at least every two (2) weeks."</p> <p>2. Clinical record #3, start of care 4/6/13, included a plan of care for certification period 8/4 to 10/2/13 with orders for skilled nursing visit frequency 1 visit per week for 9 weeks for medication set-ups and urostomy care, monthly B12 injections, biweekly for supervisory visits, and 1 time every 60 days for recertification. The record failed to evidence medication set-ups were performed by skilled nursing for weeks 1 and 4 of the certification period.</p> <p>On 9/10/13 at 12:51 PM, employee D (registered nurse) indicated the medication set-ups were not performed during those weeks.</p>						

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G000170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure skilled nursing services were provided as ordered on the plan of care in 2 of 3 patient records reviewed creating the potential to affect all the agency's patients. (#1 and #3)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 3/5/13, included a plan of care for certification period 7/3 to 8/31/13 with orders for skilled nursing visit frequency 1 time every 2 weeks times 9 weeks for med sets, supervisory visits, and every 60 days for recertification and home health aide visit frequency as 5 hours per day, 4 days per week for 1 week plus 5 hours per day times 7 days per week for 8 weeks. The record failed to evidence home health aide supervisory visits were conducted by the registered nurse from 7/12 to 8/8/13.</p> <p>A. On 9-9-13 at 12:50 PM, employee C indicated there were no supervisory visits conducted by the registered nurse between the dates of July 12 and August 8, 2013.</p>	G000170	G 0170 All skilled care givers that provide skilled nursing services will be in-serviced on the facilities policy Skilled Nursing Services by DON/ or designee.DON will mandate an alternate nurse to perform supervisory visit if scheduled nurse is unable to do so. If unable to appoint a nurse to go the DON/ADON will cover the visit.DON/ or designee provided all case managers with a contact list of all other case managers and their telephone numbers to ensure multiple routes of contact. Case managers signed a form stating they received these contact number, and was placed in all of their employee files effective on 9/23/2013.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	10/09/2013	

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	<p>B. The undated agency policy titled "Supervision of Staff" states, "Policy All staff providing home care services will be supervised as outlined by federal and state regulations and accepted standards of practice. ... Special Instructions 1. When clients are receiving skilled nursing services in addition to personal care, the Registered Nurse will make a supervisory visit to the client's residence at least every two (2) weeks."</p> <p>2. Clinical record #3, start of care 4/6/13, included a plan of care for certification period 8/4 to 10/2/13 with orders for skilled nursing visit frequency 1 visit per week for 9 weeks for medication set-ups and urostomy care, monthly B12 injections, biweekly for supervisory visits, and 1 time every 60 days for recertification. The record failed to evidence medication set-ups were performed by skilled nursing for weeks 1 and 4 of the certification period.</p> <p>On 9/10/13 at 12:51 PM, employee D (registered nurse) indicated the medication set-ups were not performed during those weeks.</p>			

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G000224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on clinical record review, document review, and interview, the agency failed to ensure the registered nurse made changes to the aide plan of care in 1 of 3 clinical records reviewed creating the potential to affect all the agency's patients that receive aide services. (#3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #3, start of care 4/6/13, contained a plan of care electronically signed by employee D (registered nurse) for certification period 8/4 to 10/2/13 which states, " HHA [home health aide] visit frequency ... 8 hrs [hours]/day x 4 days/wk [week] x 1 week + 8 hrs [hours] /day x 7 days/wk x 8 weeks ... " and a "Supplemental Plan of Care" for this certification period stating, "HHA visit frequency 7x4 [4 hours per day x 7 days per week]." The record failed to evidence the registered nurse updated the aide care plan for visit frequency. The record evidenced a document 	G000224	G 0224 The DON/ or designee will audit 100% of all patient care plans to ensure that the Aide Care Plan matches client's Plan of Care and physicians order.DON/or designee will audit all new admissions within 72 hours to ensure that aide care plan and Plan or Care both match physicians orders.DON/or designee will audit 10% of all client charts quarterly to maintain compliance.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	10/09/2013			

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	<p>titled "Aide / Homemaker Care plan" dated 7/30/13 by employee D states, "Frequency 6 hrs/day, 5 days/wk."</p> <p>3. The record evidenced a document titled "physician's Order" dated 7/30/13 by employee D which states, "Recertification Home Health Services for period 8/4/2013 - 10/7/2013 ... HHA visit frequency 8 hrs/day x 4 days/wk x 9 weeks to assist with ADLs [activities of daily living]."</p> <p>4. The record evidenced a document dated 8/2/13 by employee A (director of nursing) which states, "Order to decrease HHA hours r/t [related to] PA [prior authorization] approval Hha from 8 hrs/day x 6 days/wk to 2 hrs/day x 7 days/wk starting 8/2/13."</p> <p>5. The record evidenced a physicians written order dated 8/8/13 which states, "Due to [patient] disability, please increase HHA 3 additional units in the evening. DOS 8/1/13 to 8/30/13."</p>						

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G000229	<p>484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse made an on-site visit to the patient's home for supervision of the home health aide no less frequently than every 2 weeks in 1 of 3 clinical records reviewed of patients receiving home health aide services with the potential to affect all patients receiving nursing and home health aide services. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 3-5-13, evidenced a physicians plan of care for certification period 7-3 to 8-31-13 which states, "21. Orders for discipline and treatments: SN [skilled nursing] visit frequency ... 1 x [times] 2wks [weeks] x 9 wks for med sets, sup visits and every 60 days for recerts ... HHA [home health aide] ... 5hrs [hours]/day x 4 days/wk x 1 week + 5hrs/day x 7days/wk x 8 weeks" The record evidenced a supervisory visit of the aide was conducted by the registered nurse on 7-12-13 and 27 days</p>	G000229	G 0229 All skilled care givers that provide skilled nursing services will be in-serviced on the facilities policy Skilled Nursing Services by DON/ or designee.DON will mandate an alternate nurse to perform supervisory visit if scheduled nurse is unable to do so. If unable to appoint a nurse to go the DON/ADON will cover the visit.DON/ or designee provided all case managers with a contact list of all other case managers and their telephone numbers to ensure multiple routes of contact. Case managers signed a form stating they received these contact number, and was placed in all of their employee files effective on 9/23/2013.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	10/09/2013			

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	<p>later on 8-8-13.</p> <p>2. On 9-9-13 at 12:50 PM, employee C indicated there were no supervisory visits conducted by the registered nurse between the dates of July 12 and August 8, 2013.</p> <p>3. The undated agency policy titled "Supervision of Staff" states, "Policy All staff providing home care services will be supervised as outlined by federal and state regulations and accepted standards of practice. ... Special Instructions 1. When clients are receiving skilled nursing services in addition to personal care, the Registered Nurse will make a supervisory visit to the client's residence at least every two (2) weeks."</p>						

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G000341	<p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record review and interview, the agency failed to ensure OASIS data accurately reflected the reason for the assessment at the time of assessment in 1 of 3 patient records reviewed. (#3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #3, start of care 4/6/13, evidenced a document dated 9/2/13 by employee D (Registered Nurse) titled "Completion of Care, OASIS Data Sets, and Discharge Summary Outcome and Assessment Information Set (OASIS-C, 1/2010)" which had "Transfer to Inpatient Facility" and "Death at Home" checked as the reason for assessment and also contained a document dated 9/7/13 by employee E (registered nurse) titled "Comprehensive Adult Assessment ... Resumption of Care." 2. On 9/10/13 at 11:20 PM, employee C (alternate director of nursing) indicated the patient was admitted to the hospital on 9/2/13 at which time a transfer Oasis assessment was performed but the registered nurse did not accurately 	G000341	G0341 Nurse responsible for QA of OASIS forms given a written counseling regarding timeliness of auditing documentation. DON/ or designee will audit all OASIS forms submitted by nurses and will be returned to responsible case manager for correction of forms, to ensure that all forms are completed accurately. DON/or designee will in-service all Case Managers on the process of OASIS completion and correction. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	10/09/2013			

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N000000	<p>document on the Oasis sheet the appropriate reason for the assessment.</p> <p>This was a home health state complaint investigation survey.</p> <p>Complaint IN00135903 - Substantiated: State deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey Dates: September 9 and September 10, 2013</p> <p>Facility #: 012169</p> <p>Medicaid #: Not Available</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 13, 2013</p>	N000000			

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N000484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on clinical record review and interview, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 1 of 3 clinical records reviewed creating the potential to affect all the agency's patients. (#3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #3 included a physician's plan of care established for the certification period 8/4 to 10/2/13 with orders for skilled nursing and home health aide services. The record failed to evidence all the services maintained liaison to ensure their efforts were coordinated and supported the plan of care. On 9/9/13 at 12:01 PM, employee C indicated the aide visit frequency for this patient was not communicated between 	N000484	N 484 The DON has audited 100% of client charts, as of September 20th, 2013 to ensure that hours scheduled are following physician orders and match the Plan of Care. 10% of all client charts will be audited quarterly to ensure Plan of Care and Physician orders are matching hours scheduled. DON/ or designee will audit new admissions within 72 hour to confirm that physician hours ordered matches the client's Plan of Care and are scheduled appropriately. The PA processor and scheduler (all disciplines responsible for scheduling client care) will attend weekly, Monday, nursing meetings to verify any changes noted with any client PA, to ensure compliance in all areas. Any changes made to client schedule will conveyed to HHA/CNAs responsible for patients care, immediately, via telephone. Documentation will be noted in clients chart of notification and Case Manager will deliver the updated paperwork to clients home and place in agency folder. administrator will	10/09/2013			

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	personnel furnishing services.		be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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N000494	<p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient was provided a written notice of the patient's rights in advance of furnishing care to the patient during the initial evaluation visit before the initiation of treatment in 1 of 3 patient records reviewed creating the potential to affect all the agency's patients. (#3)</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care 4/6/13, evidenced a document titled "Comprehensive Adult Assessment" dated 4/6/13. The record failed to evidence the patient was provided a written notice of the patient's rights in</p>	N000494	N 494DON/ or designee will audit 10% of all current charts weekly until within compliance to ensure they have received a copy of patients rights and that client's chart has an accurate SOC date.DON/or designee will audit every new admission within 72 hours to ensure dated material.DON/or désignéé to accompany each case manager on SOC date for verification of knowledge or training with check off.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not occur.	10/09/2013

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	<p>advance of furnishing care to the patient.</p> <p>2. On 9/10/13 at 11:20 AM, employee C indicated there was no documentation in the patient's chart to evidence a written notice of the patient's rights was presented during the initial visit on 4/6/13 by the registered nurse.</p>			

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N000522	<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, policy review, and interview, the agency failed to ensure care care was provided as ordered on the plan of care in 2 of 3 patient records reviewed creating the potential to affect all the agency's patients. (#1 and #3)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 3/5/13, included a plan of care for certification period 7/3 to 8/31/13 with orders for skilled nursing visit frequency 1 time every 2 weeks times 9 weeks for med sets, supervisory visits, and every 60 days for recertification and home health aide visit frequency as 5 hours per day, 4 days per week for 1 week plus 5 hours per day times 7 days per week for 8 weeks. The record failed to evidence home health aide supervisory visits were conducted by the registered nurse from 7/12 to 8/8/13.</p> <p>A. On 9-9-13 at 12:50 PM, employee C indicated there were no supervisory visits conducted by the registered nurse</p>	N000522	N 522 All skilled caregivers that provide skilled nursing care will be in-serviced on the agency's policy of skilled nursing services by DON/ or designee.DON will mandate an alternate nurse to perform supervisory visit if scheduled nurse is unable to do so. If unable to appoint a nurse to go the DON/ADON will cover the visit.DON/ or designee provided all case managers with a contact list of all other case managers and their telephone numbers to ensure multiple routes of contact. Case managers signed a form stating they received these contact number, and was placed in all of their employee files effective on 9/23/2013.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	10/09/2013			

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	<p>between the dates of July 12 and August 8, 2013.</p> <p>B. The undated agency policy titled "Supervision of Staff" states, "Policy All staff providing home care services will be supervised as outlined by federal and state regulations and accepted standards of practice. ... Special Instructions 1. When clients are receiving skilled nursing services in addition to personal care, the Registered Nurse will make a supervisory visit to the client's residence at least every two (2) weeks."</p> <p>2. Clinical record #3, start of care 4/6/13, included a plan of care for certification period 8/4 to 10/2/13 with orders for skilled nursing visit frequency 1 visit per week for 9 weeks for medication set-ups and urostomy care, monthly B12 injections, biweekly for supervisory visits, and 1 time every 60 days for recertification. The record failed to evidence medication set-ups were performed by skilled nursing for weeks 1 and 4 of the certification period.</p> <p>On 9/10/13 at 12:51 PM, employee D (registered nurse) indicated the medication set-ups were not performed during those weeks.</p>						

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N000537	<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> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure skilled nursing services were provided as ordered on the plan of care in 2 of 3 patient records reviewed creating the potential to affect all the agency's patients. (#1 and #3)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 3/5/13, included a plan of care for certification period 7/3 to 8/31/13 with orders for skilled nursing visit frequency 1 time every 2 weeks times 9 weeks for med sets, supervisory visits, and every 60 days for recertification and home health aide visit frequency as 5 hours per day, 4 days per week for 1 week plus 5 hours per day times 7 days per week for 8 weeks. The record failed to evidence home health aide supervisory visits were conducted by the registered nurse from 7/12 to 8/8/13.</p> <p>A. On 9-9-13 at 12:50 PM, employee C indicated there were no supervisory visits conducted by the registered nurse</p>	N000537	N53 All skilled care givers that provide skilled nursing services will be in-serviced on the facilities policy Skilled Nursing Services by DON/ or designee.DON will mandate an alternate nurse to perform supervisory visit if scheduled nurse is unable to do so. If unable to appoint a nurse to go the DON/ADON will cover the visit.DON/ or designee provided all case managers with a contact list of all other case managers and their telephone numbers to ensure multiple routes of contact. Case managers signed a form stating they received these contact number, and was placed in all of their employee files effective on 9/23/2013.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	10/09/2013			

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	<p>between the dates of July 12 and August 8, 2013.</p> <p>B. The undated agency policy titled "Supervision of Staff" states, "Policy All staff providing home care services will be supervised as outlined by federal and state regulations and accepted standards of practice. ... Special Instructions 1. When clients are receiving skilled nursing services in addition to personal care, the Registered Nurse will make a supervisory visit to the client's residence at least every two (2) weeks."</p> <p>2. Clinical record #3, start of care 4/6/13, included a plan of care for certification period 8/4 to 10/2/13 with orders for skilled nursing visit frequency 1 visit per week for 9 weeks for medication set-ups and urostomy care, monthly B12 injections, biweekly for supervisory visits, and 1 time every 60 days for recertification. The record failed to evidence medication set-ups were performed by skilled nursing for weeks 1 and 4 of the certification period.</p> <p>On 9/10/13 at 12:51 PM, employee D (registered nurse) indicated the medication set-ups were not performed during those weeks.</p>						

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N000550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review, document review, and interview, the agency failed to ensure the registered nurse made changes to the aide plan of care in 1 of 3 clinical records reviewed creating the potential to affect all the agency's patients that receive aide services. (#3)</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care 4/6/13, contained a plan of care electronically signed by employee D (registered nurse) for certification period 8/4 to 10/2/13 which states, " HHA [home health aide] visit frequency ... 8 hrs [hours]/day x 4 days/wk [week] x 1 week + 8 hrs [hours] /day x 7 days/wk x 8 weeks ... " and a "Supplemental Plan of Care" for this certification period stating, "HHA visit frequency 7x4 [4 hours per day x 7 days per week]." The record failed to evidence the registered nurse updated the aide care plan for visit frequency.</p>	N000550	N550 The DON/ or designee will audit 100% of all patient care plans to ensure that the Aide Care Plan matches client's Plan of Care and physicians order.DON/or designee will audit all new admissions within 72 hours to ensure that aide care plan and Plan or Care both match physicians orders.DON/or designee will audit 10% of all client charts quarterly to maintain compliance.The administrator will be responsible for monitoring these corrective actions to ensuree that this deficiency is corrected and will not recur.	10/09/2013			

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	<p>2. The record evidenced a document titled "Aide / Homemaker Care plan" dated 7/30/13 by employee D states, "Frequency 6 hrs/day, 5 days/wk."</p> <p>3. The record evidenced a document titled "physician's Order" dated 7/30/13 by employee D which states, "Recertification Home Health Services for period 8/4/2013 - 10/7/2013 ... HHA visit frequency 8 hrs/day x 4 days/wk x 9 weeks to assist with ADLs [activities of daily living]."</p> <p>4. The record evidenced a document dated 8/2/13 by employee A (director of nursing) which states, "Order to decrease HHA hours r/t [related to] PA [prior authorization] approval Hha from 8 hrs/day x 6 days/wk to 2 hrs/day x 7 days/wk starting 8/2/13."</p> <p>5. The record evidenced a physicians written order dated 8/8/13 which states, "Due to [patient] disability, please increase HHA 3 additional units in the evening. DOS 8/1/13 to 8/30/13."</p>			

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N000606	<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 clinical record review, policy review, and interview, the agency failed to ensure the registered nurse made an on-site visit to the patient's home for supervision of the home health aide no less frequently than every 2 weeks in 1 of 3 clinical records reviewed of patients receiving home health aide services. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 3-5-13, evidenced a physicians plan of care for certification period 7-3 to 8-31-13 which states, "21. Orders for discipline and treatments: SN [skilled nursing] visit frequency ... 1 x [times] 2wks [weeks] x 9 wks for med sets, sup visits and every 60 days for recerts ... HHA [home health aide] ... 5hrs [hours]/day x 4 days/wk x 1 week + 5hrs/day x 7days/wk x 8 weeks" The record evidenced a supervisory visit of the aide was conducted by the registered nurse on 7-12-13 and 27 days later on 8-8-13.</p>	N000606	N 606 All skilled care givers that provide skilled nursing services will be in-serviced on the facilities policy Skilled Nursing Services by DON/ or designee.DON will mandate an alternate nurse to perform supervisory visit if scheduled nurse is unable to do so. If unable to appoint a nurse to go the DON/ADON will cover the visit.DON/ or designee provided all case managers with a contact list of all other case managers and their telephone numbers to ensure multiple routes of contact. Case managers signed a form stating they received these contact number, and was placed in all of their employee files effective on 9/23/2013.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	10/09/2013			

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	<p>2. On 9-9-13 at 12:50 PM, employee C indicated there were no supervisory visits conducted by the registered nurse between the dates of July 12 and August 8, 2013.</p> <p>3. The undated agency policy titled "Supervision of Staff" states, "Policy All staff providing home care services will be supervised as outlined by federal and state regulations and accepted standards of practice. ... Special Instructions 1. When clients are receiving skilled nursing services in addition to personal care, the Registered Nurse will make a supervisory visit to the client's residence at least every two (2) weeks."</p>			