

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157118	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2013
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NAME OF PROVIDER OR SUPPLIER AMERICAN NURSING CARE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 6515 E 82ND ST STE 112 INDIANAPOLIS, IN 46250
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G000000	<p>This visit was a Home Health federal recertification survey. This was a partially extended survey.</p> <p>Survey Dates: March 4-7, 2013 Partially Extended Survey Dates: March 7, 2013</p> <p>Facility Number: 005309</p> <p>Provider Number: 157118</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor - Team Leader David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 674 Home Health Aide Only: 6 Personal Care Only: 0 Total: 680</p> <p>Sample: RR w/HV: 2 RR w/o HV: 14 Total: 16</p>	G000000	N/A	
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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>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 policy review, record review, and interview, the home health agency failed to ensure coordination of care occurred among all personnel furnishing services and the physician for 5 of 16 clinical records reviewed with the potential to affect all patients of the agency. (#3, 5, 11, 12, and 16)</p> <p>Findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services."</p>	G000143	<p>484.14 (g) Coordination of Patient Services A mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08- Nursing Service "The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services". Policy #33.17 Medical Supervision-"Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as appropriate". Policy # 33.20 Case Conferences - Interdisciplinary Group Meeting/Coordination of Services -"Agency staff regularly communicate to assure that their</p>	04/06/2013

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	<p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Case Conferences - Coordination of Service" policy number 33.20, revised 8/24/11 states, "Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care."</p> <p>4. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p> <p>5. The policy titled "Apical Pulse" policy number 33.203, revised 6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or abnormalities of rate,</p>		<p>efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care." Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart." Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care." Clinical staff to be re-educated on notifying physician when vitals or assessment is not within parameters and documenting follow up on 3/26/13.</p> <p>In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed</p>				

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	<p>rhythm. Document physician notification in patient chart."</p> <p>6. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>7. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>8. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100. Review of the record evidenced the following:</p> <p>A. On 2/21/13, employee U, Registered Nurse (RN), documented a radial pulse of 105. The record failed to evidence the physician was</p>		<p>by Director of Clinical Services/designee. This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCM</p> <p>Client #3--Physician notified on 3/19/13 of elevated pulse from 2/21/13 Client #5--Client discharged on 2/10/13 after admission to hospital. Client #11--Client discharged on 2/28/13</p> <p>Client #12--Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, 2/18/13, 2/27/13, and 3/4/13.</p> <p>Client #16--Physician notified on 3/19/13 of vitals out of parameters on 2/19/13.</p>	

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	<p>notified of the increased pulse rate.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>9. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 and included a skilled nursing visit note dated 2/10/13 by employee X, RN, which states, "Pt's [patient's] son took [patient] to ER [Emergency Department] last night. Pt's son stated [patient's] BP [blood pressure] was low ever since [patient] came back from dialysis. Pt was treated and released. Pt's son called RN to check on pt. Pt's son stated his [parent] is not acting right and stated that he is not feeling well. RN performed PRN [as needed] visit to assess pt." Review of the record failed to evidence the RN notified the physician about the patient's recent emergency department visit.</p> <p>On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p>				

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	<p>10. Clinical record #11, start of care 2/7/13, contained a home health certification and plan of care dated 2/7/13-4/7/13 which states for skilled nursing to notify physician for diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 2/18/13, employee C, Licensed Practical Nurse (LPN), documented a diastolic blood pressure of 50. The record failed to evidence the registered nurse or physician was notified of the low diastolic blood pressure.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>11. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 1/17/13, employee C, LPN, documented a pulse of 52. The</p>				

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	<p>record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>B. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>D. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>E. On 2/18/13, employee C, LPN, documented a pulse of 55. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>F. On 2/27/13, employee Z, RN, documented "left message for Dr. [name] regarding increase in edema, denuded areas, edema, cough."</p>				

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	<p>There was no evidence in the medical record that any further follow up was completed or orders received.</p> <p>G. On 3/4/13, employee Y, RN, documented pain as a 5 out of 10 "in legs with wound care. VA [Veteran's Administration] called and message left. Legs appear to be getting worse. Antibiotic has ended. Patient states legs flaired [sic] up after antibiotic stopped ... message left for Dr. [name] on legs." There was no evidence in the medical record that any further follow up was completed or orders received.</p> <p>H. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>12. Clinical record #16, start of care 2/5/13, contained a home health certification and plan of care dated 2/5/13-4/5/13 which states for skilled nursing to notify physician of any abnormalities. On 2/19/13, employee C, LPN, documented a diastolic blood pressure of 100 and a pulse of 104. The record failed to evidence the registered nurse or physician was notified of the increased diastolic blood pressure and pulse.</p>			

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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 policy review, clinical record review, and interview, the home health agency failed to ensure skilled nursing visits, home health aide visits, occupational therapy visits, physical therapy visits and social worker visits were made in accordance with the plan of care; treatments were provided as ordered; and the physician was notified when ordered on the plan of care in 11 of 16 records reviewed with the potential to affect all the agency's patients who received skilled nursing, home health aide, occupational therapy, physical therapy, and social worker services. (#1, 2, 3, 4, 5, 6, 9, 11, 12, 15, and 16).</p> <p>The findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that</p>	G000158	<p>484.18 Acceptance of patients, POC, Med SuperA mandatory in service will be held 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08 Nursing Service-"The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinatescare with other disciplines and services". Policy #33.17 Medical Supervision-" Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as appropriate". Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician.</p>	04/06/2013

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	<p>suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services."</p> <p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p> <p>4. The policy titled "Apical Pulse" policy number 33.203, revised 6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by</p>		<p>Notify physician unless otherwise specified. Document physician notification in patient chart." Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Documentation physician notification in patient chart. Policy #33.204 Radial Pulse- "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care." Policy # 33.103 Missed Visit/Shift-"In the event that a client or an associate cancels a scheduled visit ordered by physician: 1. The visit will be rescheduled, if possible, to comply with the physician order. 2. A missed visit form will be filled out and filed in the patient record; 4. The manager/supervisor will be notified by the scheduler when a shift/visit is missed or refused: 6. The scheduler will notify the responsible physician, by fax of the missed/refused shift/visit for all cases that are not categorized as high tech.Policy #33.96 Social</p>				

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	<p>physician) or abnormalities of rate, rhythm. Document physician notification in patient chart."</p> <p>5. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>6. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>7. The policy titled "Missed Visit / Shift" policy number 33.103, revised 7/24/03 states, "In the event that a client or an associate cancels a scheduled visit ordered by the physician: 1. The visit will be rescheduled, if possible, to comply with the physician order; 2. A missed visit form will be filled out and filed in the patient record; ... 4. The Manager/Supervisor will be notified by the schedulers when a shift / visit is</p>		<p>Work Services-"Visits will be scheduled by the Medical Social Worker in accordance with the physicians order." Policy #33.11 Occupational Therapy Services-"All occupational therapy service by the company, directly or under contractual agreements are provided..in accordance with the physician plan of treatment. The duties of the therapist include the following: Develops and implements an individualized care plan in accordance with the physician plan of treatment within 5 days of the initiation of services." Policy # 33.103 Missed Visit/Shift was reviewed with schedulers on 03/12/2013.A new process was put into place on 3/11/13 to ensure the physician is notified of all missed visits and all ordered services will begin within 5 days of initiation of services. Education was given to all clinical staff and schedulers by Director of Clinical Services on 3/12/13.In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services/ designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee.This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCMClient #1-- SN missed visits completed and faxed to</p>				

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	<p>missed or refused; ... 6. The Scheduler will notify the responsible physician, by fax of the missed / refused shift / visit for all cases that are not categorized as high tech."</p> <p>8. The policy titled "Social Work Services" policy number 33.96, revised 7/24/03 states, "Visits will be scheduled by the Medical Social Worker in accordance with the physician's order."</p> <p>9. The policy titled "Occupational Therapy Services" policy number 33.11, revised 11/14/06 states, "All occupational therapy service by the Company, directly or under contractual agreements are provided ... in accordance with the physician plan of treatment. The duties of the therapist include the following: ... Develops and implements an individualized care plan in accordance with the physician plan of treatment within five (5) days of the initiation of service."</p> <p>10. Clinical record #1, start of care 11/30/12, contained a home health certification and plan of care dated 11/30/12-1/28/13 with orders for skilled nursing (SN) to visit 7 times per week for 2 weeks, 3 times per week for 2 weeks, 2 times per week</p>		<p>physician on 3/5/13. Client #2--HHA missed visit forms completed and faxed to physician on 3/5/13. Clarification order obtained 3/19/13 from physician to start OT week of 2/18/13. Client #3--Order clarification received from the physician on 3/18/13 to start MSW the week of 2/22/13. PT missed visits completed and faxed to physician on 3/5/13. Client #4--SN missed visit completed and faxed to physician on 3/5/13. Client #5--SN and HHA missed visits completed and faxed to physician on 3/5/13. Client #6--HHA missed visit form completed and faxed to physician on 3/5/13. Client #9--SN and HHA missed visit forms completed and faxed to physician on 3/5/13. Client #11--SN missed visit form completed and faxed to physician on 3/5/13. Client discharged on 2/28/13. Client #12--HHA missed forms completed and faxed to physician on 3/5/13. Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, and 2/18/13. Client #15--Physician notified on 03/19/2013 that patient/caregiver refused further services after initial SOC visit. Client #16--PT missed visit forms completed and faxed to physician on 3/4/13. Physician notified on 3/19/13 of vitals not within parameters on 2/19/13.</p>				

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	<p>for 1 week, and 1 times per week for 4 weeks. The record evidenced no skilled nursing visits were made the week of 1/11/13 and 1/18/13. No missed visit notes or physician notification were found in the record.</p> <p>11. Clinical record #2, start of care 2/12/13, contained a home health certification and plan of care dated 2/12/13-4/12/13 which states for home health aide (HHA) to visit 2 times per week for 8 weeks and Occupational Therapy (OT) to visit 1 time per week for 1 week for evaluation and treatment. Review of the record evidenced the following:</p> <p>A. No HHA visits were made the week of 2/12/13. No missed visit notes or physician notification were found in the record.</p> <p>B. No OT visit was made the week of 2/12/13. The initial OT visit was not made until 2/21/13. No missed visit notes or physician notification were found in the record.</p> <p>12. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 with orders for skilled nursing to notify physician for heart rate less than 60 or greater than 100,</p>						

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	<p>temperature greater than 100.5 Fahrenheit, and respirations less than 12 or greater than 24; Physical Therapy (PT) to visit 1 time per week for 1 week, 2 times per week for 4 weeks, and 1 time per week for 4 weeks; and Social Worker (SW) to visit 1 time per week for 1 week. Review of the record evidenced the following:</p> <p>A. On 2/14/13, employee U, Registered Nurse (RN), failed to document the patient's temperature or respirations.</p> <p>B. On 2/19/13, employee U, RN, failed to document the patient's temperature</p> <p>C. On 2/21/13, employee U, RN, documented a radial pulse of 105. The record failed to evidence the physician was notified of the increased pulse rate.</p> <p>D. No SW visit was made the week of 2/10/13. The initial SW visit was not made until 2/23/13. No missed visit notes or physician notification were found in the record.</p> <p>E. No PT visits were made the week of 2/15/13 and 2/22/13. A missed visit note dated 3/5/13 was found in the</p>			

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	<p>record which states, "late entry - effective 2/18/2013 client on hold secondary too sick to do PT."</p> <p>On 3/5/13 at 4:10 PM, employee I, Administrator, indicated the missed visit note should have been made by the end of the week the missed visit occurred.</p> <p>F. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>13. Clinical record #4, start of care 11/28/12, contained a home health certification and plan of care dated 01/27/13-03/27/13 with orders for SN to visit 1 time per week for 9 weeks. The record evidenced no SN visits were made the week of 1/25/13 and 2/8/13. No missed visit notes or physician notification were found in the record.</p> <p>14. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 with orders for HHA to visit 2 times per week for 8 weeks and SN to visit 1 time per week for 1 week, 2 times per week for 1 week, and 1 time per week for 7 weeks.</p>			

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	<p>Review of the record evidenced the following:</p> <p>A. No HHA visits were made the weeks of 2/6/13, 2/8/13, 2/15/13, or 2/22/13. No missed visit notes or physician notification were found in the record.</p> <p>B. Only 1 SN visit was made the week of 2/8/13 and no SN visits were made the weeks of 2/15/13 or 2/22/13. No missed visit notes or physician notification were found in the record.</p> <p>15. Clinical record #6, start of care 6/15/12, contained a home health certification and plan of care dated 2/10/13-4/10/13 with orders for HHA 3 times per week for 8 weeks. The record evidenced only 2 HHA visits were made the week of 2/8/13. No missed visit note or physician notification was found in the record.</p> <p>16. Clinical record #9, start of care 1/24/13, contained a home health certification and plan of care dated 1/24/13-3/24/13 with orders for SN 1 time per week for 9 weeks and HHA to begin on 2/22/13 for 2 times per week for 3 weeks. Review of the record evidenced the following:</p>						

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	<p>A. No SN visits were made the week of 2/1/13. No missed visit note or physician notification was found in the record.</p> <p>B. No HHA visits were made the week of 2/22/13. No missed visit notes or physician notification were found in the record.</p> <p>17. Clinical record #11, start of care 2/7/13, contained a home health certification and plan of care dated 2/7/13-4/7/13 with orders for skilled nursing 1 time per week for 1 week, 2 times per week for 2 weeks, and 1 time per week for 2 weeks; and orders for SN to notify physician for diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. Only 1 SN visit was made the week of 2/8/13. No missed visit note or physician notification was found in the record.</p> <p>B. On 2/18/13, employee C, Licensed Practical Nurse (LPN), documented a diastolic blood pressure of 50. The record failed to evidence the registered nurse or physician was notified of the low diastolic blood pressure.</p>						

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	<p>C. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>18. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 with orders for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90; and orders for HHA 2 times per week for 9 weeks. Review of the record evidenced the following:</p> <p>A. On 1/17/13, employee C, LPN, documented a pulse of 52. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>B. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of</p>				

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	<p>the decreased diastolic blood pressure.</p> <p>D. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>E. On 2/18/13, employee C, LPN, documented a pulse of 55. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>F. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>G. There were HHA missed visits the weeks of 1/14, 1/18, 1/25, 2/8, 2/15, and 2/22. No missed visit notes or physician notification were found in the record.</p> <p>19. Clinical record #15, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for PT 1 time per week for 1 week for evaluation and treatment and OT 1 time per week for 1 week for</p>				

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	<p>evaluation and treatment. Review of the record evidenced the following:</p> <p>A. No PT visit was made the week of 2/2/13. No missed visit notes or physician notification were found in the record for the week of 2/2/13.</p> <p>B. No OT visit was made the week of 2/2/13. No missed visit notes or physician notification were found in the record for the week of 2/2/13.</p> <p>20. Clinical record #16, start of care 2/5/13, contained a home health certification and plan of care dated 2/5/13-4/5/13 with orders for skilled nursing to notify physician of any abnormalities and for PT to begin 2/7/13 for 1 time per week for 1 week and 2 times per week for 4 weeks. Review of the record evidenced the following:</p> <p>A. On 2/19/13, employee C, LPN, documented a diastolic blood pressure of 100 and a pulse of 104. The record failed to evidence the registered nurse or physician was notified of the increased diastolic blood pressure and pulse.</p> <p>B. There were PT missed visits on 2/12/13, 2/14/13 and 2/21/13. The missed visit notes were not</p>						

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	completed until 3/4/13.			

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G000164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure physician was notified regarding changes in the patient's condition for 5 of 16 clinical records reviewed with the potential to affect all patients of the agency. (#3, 5, 11, 12, and 16)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services." The policy titled "Medical Supervision" policy number 33.17, 	G000164	<p>484.18 (b) Periodic Review of Plan of CareA mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08 Nursing Service-"The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services". Policy #33.17 Medical Supervision-" Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as appropriate". Policy # 33.20 Case Conferences - Interdisciplinary Group Meeting/Coordination of Services "Agency staff regularly communicate to assure that their efforts are coordinated effectively</p>	04/06/2013	

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	<p>revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Case Conferences - Coordination of Service" policy number 33.20, revised 8/24/11 states, "Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care."</p> <p>4. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p> <p>5. The policy titled "Apical Pulse" policy number 33.203, revised 6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or abnormalities of rate, rhythm. Document physician notification in patient chart."</p>		<p>and ultimately support the objectives outlined in the plan of care." Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart." Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care."In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee. This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCMClient #3-Physician notified on 3/19/13 of</p>	

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	<p>6. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>7. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>8. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100. Review of the record evidenced the following:</p> <p>A. On 2/21/13, employee U, Registered Nurse (RN), documented a radial pulse of 105. The record failed to evidence the physician was notified of the increased pulse rate.</p>		<p>elevated pulse from 2/21/13Client #5--Client discharged on 2/10/13 after hospitalizationClient #11--Client discharged on 2/28/13Client #12--Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, 2/18/13, 2/27/13, and 3/4/13Client #16--Physician notified on 3/19/13 of vitals not within parameters on 2/19/13.</p>				

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	<p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>9. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 and included a skilled nursing visit note dated 2/10/13 by employee X, RN, which states, "Pt's [patient's] son took [patient] to ER [Emergency Department] last night. Pt's son stated [patient's] BP [blood pressure] was low ever since [patient] came back from dialysis. Pt was treated and released. Pt's son called RN to check on pt. Pt's son stated his [parent] is not acting right and stated that he is not feeling well. RN performed PRN [as needed] visit to assess pt." Review of the record failed to evidence the RN notified the physician about the patient's recent emergency department visit.</p> <p>On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>10. Clinical record #11, start of care 2/7/13, contained a home health</p>				

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(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	
	<p>certification and plan of care dated 2/7/13-4/7/13 which states for skilled nursing to notify physician for diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 2/18/13, employee C, Licensed Practical Nurse (LPN), documented a diastolic blood pressure of 50. The record failed to evidence the registered nurse or physician was notified of the low diastolic blood pressure.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>11. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 1/17/13, employee C, LPN, documented a pulse of 52. The record failed to evidence the registered nurse or physician was</p>				

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	<p>notified of the decreased pulse rate.</p> <p>B. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>D. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>E. On 2/18/13, employee C, LPN, documented a pulse of 55. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>F. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p>			

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	<p>12. Clinical record #16, start of care 2/5/13, contained a home health certification and plan of care dated 2/5/13-4/5/13 which states for skilled nursing to notify physician of any abnormalities. On 2/19/13, employee C, LPN, documented a diastolic blood pressure of 100 and a pulse of 104. The record failed to evidence the registered nurse or physician was notified of the increased diastolic blood pressure and pulse.</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 policy review, clinical record review, and interview, the home health agency failed to ensure skilled nursing visits were made in accordance with the plan of care, treatments were provided as ordered, and physician notification was made as ordered per the plan of care in 7 of 16 records reviewed with the potential to affect all the agency's patients who received skilled nursing services. (#1, 3, 4, 5, 9, 11, and 12).</p> <p>The findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and</p>	G000170	484.30 Skilled Nursing Service A mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08 Nursing Service-"The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services" Policy #33.17 Medical Supervision-" Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as appropriate". Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or	04/06/2013			

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	<p>services."</p> <p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>4. Clinical record #1, start of care 11/30/12, contained a home health certification and plan of care dated 11/30/12-1/28/13 with orders for skilled nursing to visit 7 times per week for 2 weeks, 3 times per week for 2 weeks, 2 times per week for 1 week, and 1 times per week for 4 weeks. The record evidenced no skilled nursing visits were made the week of 1/11/13 and 1/18/13.</p> <p>5. Clinical record #3, start of care</p>		<p>condition that suggests a need to alter the plan of care."Re-education to be provided to clinical staff on documenting a full set of vitals on every visit by Director of Clinical Services on 3/26/13A new process was put into place on 3/11/13 to ensure the physician is notified of all missed visits. Education was given to all clinical staff and schedulers by Director of Clinical Services on 3/12/13.In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee.This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCMClient #1--SN missed visit forms completed and faxed to physician on 3/5/13Client #3--Physician notified on 3/19/13 of elevated pulse from 2/21/13Client #4--SN missed visit forms completed and faxed to physician on 3/5/13Client #5--SN missed visit forms completed and faxed to physician on 3/5/13Client #9--SN missed visit forms completed and faxed to physician on 3/5/13Client #11--SN missed visit forms completed and faxed to physician on 3/5/13Client #12--Physician notified on 3/19/13 of all vitals not within parameters for dates</p>		

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	<p>2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 with orders for skilled nursing to notify physician for heart rate less than 60 or greater than 100, temperature greater than 100.5 Fahrenheit, and respirations less than 12 or greater than 24. Review of the record evidenced the following:</p> <p>A. On 2/14/13, employee U, Registered Nurse (RN), failed to document the patient's temperature or respirations.</p> <p>B. On 2/19/13, employee U, RN, failed to document the patient's temperature</p> <p>C. On 2/21/13, employee U, RN, documented a radial pulse of 105. The record failed to evidence the physician was notified of the increased pulse rate.</p> <p>D. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>6. Clinical record #4, start of care 11/28/12, contained a home health certification and plan of care dated 01/27/13-03/27/13 with orders for</p>		1/17/13, 1/19/13, 1/23/13, 2/16/13, 2/18/13, 2/27/13, and 3/4/13.		

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	<p>Skilled Nursing (SN) to visit 1 time per week for 9 weeks. The record evidenced no SN visits were made the week of 1/25/13 and 2/8/13.</p> <p>7. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 with orders for SN to visit 1 time per week for 1 week, 2 times per week for 1 week, and 1 time per week for 7 weeks. The record evidenced only 1 SN visit was made the week of 2/8/13 and no SN visits were made the week of 2/15/13 or 2/22/13.</p> <p>8. Clinical record #9, start of care 1/24/13, contained a home health certification and plan of care dated 1/24/13-3/24/13 with orders for SN 1 time per week for 9 weeks. The record evidenced no SN visits were made the week of 2/1/13.</p> <p>9. Clinical record #11, start of care 2/7/13, contained a home health certification and plan of care dated 2/7/13-4/7/13 with orders for skilled nursing 1 time per week for 1 week, 2 times per week for 2 weeks, and 1 time per week for 2 weeks. The record evidenced only 1 SN visit was made the week of 2/8/13.</p>			

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	<p>10. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 with orders for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>B. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>D. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show physician notification</p>			

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	was made.			

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G000176	<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.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the registered nurse notified the physician of changes in the patient's condition for 3 of 16 clinical records reviewed with the potential to affect all patients of the agency. (#3, 5, and 12)</p> <p>Findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services."</p>	G000176	<p>484.30(a) Duties of the Registered NurseA mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08 Nursing Service-"The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services". Policy #33.17 Medical Supervision-" Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as appropriate". Policy # 33.20 Case Conferences - Interdisciplinary Group Meeting/Coordination of Services-"Agency staff regularly</p>	04/06/2013

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	<p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Case Conferences - Coordination of Service" policy number 33.20, revised 8/24/11 states, "agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care."</p> <p>4. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p> <p>5. The policy titled "Apical Pulse" policy number 33.203, revised 6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or abnormalities of rate,</p>		<p>communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care." Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart." Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care."In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee. This process will be under the direct supervision of the Director of Operations with</p>	

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	<p>rhythm. Document physician notification in patient chart."</p> <p>6. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>7. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>8. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100. Review of the record evidenced the following:</p> <p>A. On 2/21/13, employee U, Registered Nurse (RN), documented a radial pulse of 105. The record failed to evidence the physician was</p>		<p>oversight by RVP/RCMClient #3--Physician notified on 3/19/13 of elevated pulse from 2/21/13. Client #5--Client discharged on 2/10/13 after admission to hospitalClient #12--Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, 2/18/13, 2/27/13, and 3/4/13.</p>	

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	<p>notified of the increased pulse rate.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>9. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 and included a skilled nursing visit note dated 2/10/13 by employee X, RN, which states, "Pt's [patient's] son took [patient] to ER [Emergency Department] last night. Pt's son stated [patient's] BP [blood pressure] was low ever since [patient] came back from dialysis. Pt was treated and released. Pt's son called RN to check on pt. Pt's son stated his [parent] is not acting right and stated that he is not feeling well. RN performed PRN [as needed] visit to assess pt." Review of the record failed to evidence the RN notified the physician about the patient's recent emergency department visit.</p> <p>On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p>				

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	<p>10. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>B. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>D. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show physician notification</p>			

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	was made.			

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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.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure the home health aide plan of care was updated at least every 60 days as required by agency policy and the registered nurse included all relevant information of the home health aide plan of care in 2 of 5 records reviewed of patients receiving home health aide services with the potential to affect all patients receiving home health aide services. (#6 and 12)</p> <p>The findings include:</p> <p>1. The policy titled "Homemaker / Home Health Aide Care Plan and Assignment Sheet" policy number 33.37, with a revision date of 8/25/11 states, "Any client that has a home health aide/homemaker as part of their Plan of Care must have a Home Health Aide/Homemaker Care Plan and Assignment Sheet completed at the time of admission by the Clinician</p>	G000224	<p>484.36(c)(1) Assignment & Duties of Home Health AideA mandatory in service will be held 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding Policy #33.37 Care Planning Process-"Any client that has a home health aide/homemaker as part of their plan of care must have a Home Health Aide/Homemaker care plan and assignment sheet completed at the time of admission by the clinician or whenever there are significant changes in the clients needs or condition but at least annually..Safety/Special Precautions section is individualized according to the care required for each client. This could include falls risk.. The assignment sheet is to be reviewed at a minimum of every 60 days or as needed by the clinician. This review is to be documented with date and signature under SPECIFIC INSTRUCTIONS AND DOCUMENTATION section."In order to show compliance 6</p>	04/06/2013

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	<p>or whenever there are significant changes in the client's needs or condition but at least annually ... Safety/Special Precautions section is individualized according to the care required for each client. This could include falls risk ... The assignment sheet is to be reviewed at a minimum of every 60 days or as needed by the Clinician. This review it to be documented with the date and signature under SPECIFIC INSTRUCTIONS AND DOCUMENTATION section."</p> <p>2. Clinical record #6, start of care 6/15/12, contained a home health certification and plan of care dated 2/10/13-4/10/13 and evidenced a Home Health Aide (HHA) care plan that had not been updated every 60 days. The last HHA care plan was dated 10/9/2012.</p> <p>3. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 and evidenced a HHA care plan dated 1/14/13. The care plan had a section titled "Fall Risk" which was blank.</p> <p>A. During a home visit on 3/6/13 at 2:00 PM, patient #12 reported they fell during a bath while the Home</p>		<p>randomly chosen clinical records with home health aide services will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee. This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCMClient #6--HHA careplan updated on 3/19/13Client #12--HHA careplan updated including falls risk on 3/19/13. All patients receiving home health aide services will have the careplan reviewed/updated by 4/16/2013</p>				

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	<p>Health Aide (HHA) was there.</p> <p>B. The Skilled Nursing Admission Visit, dated 1/4/13, indicates a fall risk score of 10.</p> <p>C. During an interview on 3/7/13 at 1:10 PM, employee I, Administrator, indicated the HHA care plan should have noted the patient was a fall risk.</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.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the registered nurse (RN) completed a transfer assessment within 48 hours of when the patient was transferred to an inpatient facility for 2 of 3 records reviewed of a patient transferred to an inpatient facility with the potential to affect all patients who are transferred. (#5 and 15)</p> <p>Findings:</p> <p>1. The policy titled "OASIS Management" policy number 33.106, revised 6/9/08 states, "Transfer OASIS completed anytime a client is transferred to an inpatient facility for more than 24 hours ... complete within 48 hrs of transfer to inpatient facility, or as soon as the company becomes aware of the transfer."</p> <p>2 Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13. The record evidenced an order with a begin date of 2/11/13</p>	G000341	<p>484.55(d)(3) Update of the Comprehensive AssessmentA mandatory in service will be held on 3/26/13 by the Director of Clinical Services / designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding Policy # 33.106Oasis Management-"Transfer oasis completed anytime a client is transferred to an inpatient facility for more than 24 hours-- -complete within 48 hours of transfer to inpatient facility, or as soon as the company becomes aware of transfer." In order to show compliance 4 clinical records will be chosen from patients that were transferred. These records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee. This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCMClient #5--Client discharged on 2/10/13 after readmission to hospital. Client #15--Client discharged after readmission to hospital on 2/21/13</p>	04/06/2013

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	<p>that stated, "SN [skilled nurse] - Stop all home health services due to admission to inpatient facility." The order was not entered until 3/5/13 by employee X, RN.</p> <p>Employee X, RN, completed the transfer to Inpatient Facility OASIS indicating the patient was transferred to an inpatient facility on 2/11/13. The transfer to Inpatient Facility OASIS was not completed until 3/5/13, more than 48 hours after the transfer occurred.</p> <p>3. Clinical record #15, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13. The record evidenced a missed visit note for Occupational Therapy for 2/18/13 that states "Daughter called to report patient in the process of hospitalization."</p> <p>Employee Y, RN, completed the transfer to Inpatient Facility OASIS indicating the patient was transferred to an inpatient facility on 2/14/13. The transfer to Inpatient Facility OASIS was not completed until 3/6/13, more than 48 hours after the transfer occurred.</p> <p>4. On 3/7/13 at 1:30 PM, employee I, Administrator, indicated the RN has</p>			

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	48 hours to do a transfer when a patient transfers to an inpatient facility.			

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N000000	<p>This visit was a Home Health state licensure survey.</p> <p>Survey Dates: March 4-7, 2013</p> <p>Facility Number: 005309</p> <p>Provider Number: 157118</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor - Team Leader</p> <p style="padding-left: 40px;">David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type:</p> <p>Skilled: 674</p> <p>Home Health Aide Only: 6</p> <p>Personal Care Only: 0</p> <p>Total: 680</p> <p>Sample:</p> <p>RR w/HV: 2</p> <p>RR w/o HV: 14</p> <p>Total: 16</p>	N000000	N/A		

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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 policy review, record review, and interview, the home health agency failed to ensure coordination of care occurred among all personnel furnishing services and the physician for 5 of 16 clinical records reviewed with the potential to affect all patients of the agency. (#3, 5, 11, 12, and 16)</p> <p>Findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client</p>	N000484	<p>410 IAC 17-12-2(g) QA and performance improvementA mandatory in service will be held on 3/26/13 by the Director of Clinical Services / designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08 Nursing Service-"The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services". Policy #33.17 Medical Supervision-" Physicianwill be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as</p>	04/06/2013

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	<p>conditions and needs, coordinates care with other disciplines and services."</p> <p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Case Conferences - Coordination of Service" policy number 33.20, revised 8/24/11 states, "Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care."</p> <p>4. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p> <p>5. The policy titled "Apical Pulse" policy number 33.203, revised</p>		<p>appropriate". Policy # 33.20 Case Conferences - Interdisciplinary Group Meeting/Coordination of Services-"Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care." Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart." Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care." Clinical staff to be re-educated on notifying physician when vitals or assessment is not within parameters and documenting follow up on 3/26/13. Policy #33.201 Blood Pressure-"When</p>		

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	<p>6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or abnormalities of rate, rhythm. Document physician notification in patient chart."</p> <p>6. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>7. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>8. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100. Review of the record evidenced the following:</p>		<p>clients baseline isunknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care."Clinical staff to be re-educated on notifying physician when vitals or assessment is not within parameters and documenting follow up on 3/26/13.Policy #33.201 Blood Pressure-"When clients baseline isunknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless</p>	

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	<p>A. On 2/21/13, employee U, Registered Nurse (RN), documented a radial pulse of 105. The record failed to evidence the physician was notified of the increased pulse rate.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>9. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 and included a skilled nursing visit note dated 2/10/13 by employee X, RN, which states, "Pt's [patient's] son took [patient] to ER [Emergency Department] last night. Pt's son stated [patient's] BP [blood pressure] was low ever since [patient] came back from dialysis. Pt was treated and released. Pt's son called RN to check on pt. Pt's son stated his [parent] is not acting right and stated that he is not feeling well. RN performed PRN [as needed] visit to assess pt." Review of the record failed to evidence the RN notified the physician about the patient's recent emergency department visit.</p> <p>On 3/14/13 at 9:40 AM, employee I, administrator, indicated no</p>		<p>specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care."Clinical staff to be re-educated on notifying physician when vitals or assessment is not within parameters and documenting follow up on 3/26/13.In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee.This process will be under the direct supervision of the Director of Operations with oversight by RVP/RMCClient #3--Physician notified on 3/19/13 of elevated pulse from 2/21/13 Client #5--Client discharged on 2/10/13 after admission to hospital.Client #11--Client discharged on 2/28/13Client #12--Physician notified on 3/19/13 of all vitals not</p>		

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	<p>documentation was found in the record to show physician notification was made.</p> <p>10. Clinical record #11, start of care 2/7/13, contained a home health certification and plan of care dated 2/7/13-4/7/13 which states for skilled nursing to notify physician for diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 2/18/13, employee C, Licensed Practical Nurse (LPN), documented a diastolic blood pressure of 50. The record failed to evidence the registered nurse or physician was notified of the low diastolic blood pressure.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>11. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of</p>		<p>within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, 2/18/13, 2/27/13, and 3/4/13. Client #16--Physician notified on 3/19/13 of vitals not within parameters on 2/19/13.</p>				

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	<p>the record evidenced the following:</p> <p>A. On 1/17/13, employee C, LPN, documented a pulse of 52. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>B. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>D. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>E. On 2/18/13, employee C, LPN, documented a pulse of 55. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p>			

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	<p>F. On 2/27/13, employee Z, RN, documented "left message for Dr. [name] regarding increase in edema, denuded areas, edema, cough." There was no evidence in the medical record that any further follow up was completed or orders received.</p> <p>G. On 3/4/13, employee Y, RN, documented pain as a 5 out of 10 "in legs with wound care. VA [Veteran's Administration] called and message left. Legs appear to be getting worse. Antibiotic has ended. Patient states legs flaired [sic] up after antibiotic stopped ... message left for Dr. [name] on legs." There was no evidence in the medical record that any further follow up was completed or orders received.</p> <p>H. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>12. Clinical record #16, start of care 2/5/13, contained a home health certification and plan of care dated 2/5/13-4/5/13 which states for skilled nursing to notify physician of any abnormalities. On 2/19/13, employee C, LPN, documented a diastolic blood pressure of 100 and a pulse of 104.</p>			

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	The record failed to evidence the registered nurse or physician was notified of the increased diastolic blood pressure and pulse.			

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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 policy review, clinical record review, and interview, the home health agency failed to ensure skilled nursing visits, home health aide visits, occupational therapy visits, physical therapy visits and social worker visits were made in accordance with the plan of care; treatments were provided as ordered; and the physician was notified when ordered on the plan of care in 11 of 16 records reviewed with the potential to affect all the agency's patients who received skilled nursing, home health aide, occupational therapy, physical therapy, and social worker services. (#1, 2, 3, 4, 5, 6, 9, 11, 12, 15, and 16).</p> <p>The findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that</p>	N000522	<p>410 IAC 17-13-1(a) Patient CareA mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08- Nursing Service "The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services". Policy #33.17 Medical Supervision-" Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as appropriate". Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify</p>	04/06/2013

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	<p>suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services."</p> <p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p> <p>4. The policy titled "Apical Pulse" policy number 33.203, revised 6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by</p>		<p>physician unless otherwise specified. Document physician notification in patient chart."Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care." Policy # 33.103 Missed Visit/Shift-"In the event that a client or an associate cancels a scheduled visit ordered by physician: 1. The visit will be rescheduled, if possible, to comply with the physician order. 2. A missed visit form will be filled out and filed in the patient record; 4. The manager/supervisor will be notified by the schedulers when a shift/visit is missed or refused: 6. The scheduler will notify the responsible physician, by fax of the missed /refused shift/visit for all cases that are not categorized as high tech. Policy #33.96 Social Work Services-"Visits will be scheduled by the Medical Social</p>				

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	<p>physician) or abnormalities of rate, rhythm. Document physician notification in patient chart."</p> <p>5. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>6. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>7. The policy titled "Missed Visit / Shift" policy number 33.103, revised 7/24/03 states, "In the event that a client or an associate cancels a scheduled visit ordered by the physician: 1. The visit will be rescheduled, if possible, to comply with the physician order; 2. A missed visit form will be filled out and filed in the patient record; ... 4. The Manager/Supervisor will be notified by the schedulers when a shift / visit is</p>		<p>Worker in accordance with the physicians order." Policy # 33.11 Occupational Therapy Services-"All occupational therapy service by the company, directly or under contractual agreements are provided..in accordance with thephysician plan of treatment. The duties of the therapist include the following: Develops and implementsan individualized care plan inaccordance with the physician plan of treatment within 5 days of the initiation of services." Policy # 33.103 Missed Visit/Shift was reviewed with schedulers on 03/12/2013.A new process was put into place on 3/11/13 to ensure the physician is notified of all missed visits and all ordered services will begin within 5 days of initiation of services. Education given to all clinical staff and schedulers by Director of Clinical Services on 3/12/13.In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee.This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCMClient #1-- SN missed visits completed and faxed to physician on 3/5/13.Client #2--HHA missed visit forms</p>				

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	<p>missed or refused; ... 6. The Scheduler will notify the responsible physician, by fax of the missed / refused shift / visit for all cases that are not categorized as high tech."</p> <p>8. The policy titled "Social Work Services" policy number 33.96, revised 7/24/03 states, "Visits will be scheduled by the Medical Social Worker in accordance with the physician's order."</p> <p>9. The policy titled "Occupational Therapy Services" policy number 33.11, revised 11/14/06 states, "All occupational therapy service by the Company, directly or under contractual agreements are provided ... in accordance with the physician plan of treatment. The duties of the therapist include the following: ... Develops and implements an individualized care plan in accordance with the physician plan of treatment within five (5) days of the initiation of service."</p> <p>10. Clinical record #1, start of care 11/30/12, contained a home health certification and plan of care dated 11/30/12-1/28/13 with orders for skilled nursing (SN) to visit 7 times per week for 2 weeks, 3 times per week for 2 weeks, 2 times per week</p>		<p>completed and faxed to physician on 3/5/13. Clarification order obtained 3/19/13 from physician to start OT week of 2/18/13. Client #3--Order clarification received from the physician on 3/18/13 to start MSW the week of 2/22/13. PT missed visits completed and faxed to physician on 3/5/13. Client #4--SN missed visit completed and faxed to physician on 3/5/13. Client #5--SN and HHA missed visits completed and faxed to physician on 3/5/13. Client #6--HHA missed visit form completed and faxed to physician on 3/5/13. Client #9--SN and HHA missed visit forms completed and faxed to physician on 3/5/13. Client #11--SN missed visit form completed and faxed to physician on 3/5/13. Client discharged on 2/28/13. Client #12--HHA missed forms completed and faxed to physician on 3/5/13. Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, and 2/18/13. Client #15--Physician notified on 03/19/2013 that patient/caregiver refused further services after initial SOC visit. Client #16--PT missed visit forms completed and faxed to physician on 3/4/13. Physician notified on 3/19/13 of vitals not within parameters on 2/19/13.</p>		

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	<p>for 1 week, and 1 times per week for 4 weeks. The record evidenced no skilled nursing visits were made the week of 1/11/13 and 1/18/13. No missed visit notes or physician notification were found in the record.</p> <p>11. Clinical record #2, start of care 2/12/13, contained a home health certification and plan of care dated 2/12/13-4/12/13 which states for home health aide (HHA) to visit 2 times per week for 8 weeks and Occupational Therapy (OT) to visit 1 time per week for 1 week for evaluation and treatment. Review of the record evidenced the following:</p> <p>A. No HHA visits were made the week of 2/12/13. No missed visit notes or physician notification were found in the record.</p> <p>B. No OT visit was made the week of 2/12/13. The initial OT visit was not made until 2/21/13. No missed visit notes or physician notification were found in the record.</p> <p>12. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 with orders for skilled nursing to notify physician for heart rate less than 60 or greater than 100,</p>			

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	<p>temperature greater than 100.5 Fahrenheit, and respirations less than 12 or greater than 24; Physical Therapy (PT) to visit 1 time per week for 1 week, 2 times per week for 4 weeks, and 1 time per week for 4 weeks; and Social Worker (SW) to visit 1 time per week for 1 week. Review of the record evidenced the following:</p> <p>A. On 2/14/13, employee U, Registered Nurse (RN), failed to document the patient's temperature or respirations.</p> <p>B. On 2/19/13, employee U, RN, failed to document the patient's temperature</p> <p>C. On 2/21/13, employee U, RN, documented a radial pulse of 105. The record failed to evidence the physician was notified of the increased pulse rate.</p> <p>D. No SW visit was made the week of 2/10/13. The initial SW visit was not made until 2/23/13. No missed visit notes or physician notification were found in the record.</p> <p>E. No PT visits were made the week of 2/15/13 and 2/22/13. A missed visit note dated 3/5/13 was found in the</p>				

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	<p>record which states, "late entry - effective 2/18/2013 client on hold secondary too sick to do PT."</p> <p>On 3/5/13 at 4:10 PM, employee I, Administrator, indicated the missed visit note should have been made by the end of the week the missed visit occurred.</p> <p>F. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>13. Clinical record #4, start of care 11/28/12, contained a home health certification and plan of care dated 01/27/13-03/27/13 with orders for SN to visit 1 time per week for 9 weeks. The record evidenced no SN visits were made the week of 1/25/13 and 2/8/13. No missed visit notes or physician notification were found in the record.</p> <p>14. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 with orders for HHA to visit 2 times per week for 8 weeks and SN to visit 1 time per week for 1 week, 2 times per week for 1 week, and 1 time per week for 7 weeks.</p>						

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	<p>Review of the record evidenced the following:</p> <p>A. No HHA visits were made the weeks of 2/6/13, 2/8/13, 2/15/13, or 2/22/13. No missed visit notes or physician notification were found in the record.</p> <p>B. Only 1 SN visit was made the week of 2/8/13 and no SN visits were made the weeks of 2/15/13 or 2/22/13. No missed visit notes or physician notification were found in the record.</p> <p>15. Clinical record #6, start of care 6/15/12, contained a home health certification and plan of care dated 2/10/13-4/10/13 with orders for HHA 3 times per week for 8 weeks. The record evidenced only 2 HHA visits were made the week of 2/8/13. No missed visit note or physician notification was found in the record.</p> <p>16. Clinical record #9, start of care 1/24/13, contained a home health certification and plan of care dated 1/24/13-3/24/13 with orders for SN 1 time per week for 9 weeks and HHA to begin on 2/22/13 for 2 times per week for 3 weeks. Review of the record evidenced the following:</p>			

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	<p>A. No SN visits were made the week of 2/1/13. No missed visit note or physician notification was found in the record.</p> <p>B. No HHA visits were made the week of 2/22/13. No missed visit notes or physician notification were found in the record.</p> <p>17. Clinical record #11, start of care 2/7/13, contained a home health certification and plan of care dated 2/7/13-4/7/13 with orders for skilled nursing 1 time per week for 1 week, 2 times per week for 2 weeks, and 1 time per week for 2 weeks; and orders for SN to notify physician for diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. Only 1 SN visit was made the week of 2/8/13. No missed visit note or physician notification was found in the record.</p> <p>B. On 2/18/13, employee C, Licensed Practical Nurse (LPN), documented a diastolic blood pressure of 50. The record failed to evidence the registered nurse or physician was notified of the low diastolic blood pressure.</p>			

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	<p>C. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>18. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 with orders for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90; and orders for HHA 2 times per week for 9 weeks. Review of the record evidenced the following:</p> <p>A. On 1/17/13, employee C, LPN, documented a pulse of 52. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>B. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of</p>			

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	<p>the decreased diastolic blood pressure.</p> <p>D. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>E. On 2/18/13, employee C, LPN, documented a pulse of 55. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>F. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>G. There were HHA missed visits the weeks of 1/14, 1/18, 1/25, 2/8, 2/15, and 2/22. No missed visit notes or physician notification were found in the record.</p> <p>19. Clinical record #15, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for PT 1 time per week for 1 week for evaluation and treatment and OT 1 time per week for 1 week for</p>			

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	<p>evaluation and treatment. Review of the record evidenced the following:</p> <p>A. No PT visit was made the week of 2/2/13. No missed visit notes or physician notification were found in the record for the week of 2/2/13.</p> <p>B. No OT visit was made the week of 2/2/13. No missed visit notes or physician notification were found in the record for the week of 2/2/13.</p> <p>20. Clinical record #16, start of care 2/5/13, contained a home health certification and plan of care dated 2/5/13-4/5/13 with orders for skilled nursing to notify physician of any abnormalities and for PT to begin 2/7/13 for 1 time per week for 1 week and 2 times per week for 4 weeks. Review of the record evidenced the following:</p> <p>A. On 2/19/13, employee C, LPN, documented a diastolic blood pressure of 100 and a pulse of 104. The record failed to evidence the registered nurse or physician was notified of the increased diastolic blood pressure and pulse.</p> <p>B. There were PT missed visits on 2/12/13, 2/14/13 and 2/21/13. The missed visit notes were not</p>				

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	completed until 3/4/13.				

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N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure physician was notified regarding changes in the patient's condition for 5 of 16 clinical records reviewed with the potential to affect all patients of the agency. (#3, 5, 11, 12, and 16)</p> <p>Findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services."</p>	N000527	<p>410 IAC 17-13-1(a)(2) Patient CareA mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08 Nursing Service- "The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services". Policy #33.17 Medical Supervision-" Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as appropriate". Policy #33.20 Case Conferences - Interdisciplinary Group Meeting/Coordination of</p>	04/06/2013

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	<p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Case Conferences - Coordination of Service" policy number 33.20, revised 8/24/11 states, "Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care."</p> <p>4. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p> <p>5. The policy titled "Apical Pulse" policy number 33.203, revised 6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by</p>		<p>Services "Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care." Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart." Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care."In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee. This process will be under the direct supervision of the</p>		

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	<p>physician) or abnormalities of rate, rhythm. Document physician notification in patient chart."</p> <p>6. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>7. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>8. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100. Review of the record evidenced the following:</p> <p>A. On 2/21/13, employee U, Registered Nurse (RN), documented a radial pulse of 105. The record</p>		<p>Director of Operations with oversight by RVP/RCMClient #3--Physician notified on 3/19/13 of elevated pulse from 2/21/13Client #5--Client discharged on 2/10/13 after hospitalizationClient #11--Client discharged on 2/28/13Client #12--Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, 2/18/13, 2/27/13, and 3/4/13Client #16--Physician notified on 3/19/13 of vitals out of parameters on 2/19/13.</p>	

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	<p>failed to evidence the physician was notified of the increased pulse rate.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>9. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 and included a skilled nursing visit note dated 2/10/13 by employee X, RN, which states, "Pt's [patient's] son took [patient] to ER [Emergency Department] last night. Pt's son stated [patient's] BP [blood pressure] was low ever since [patient] came back from dialysis. Pt was treated and released. Pt's son called RN to check on pt. Pt's son stated his [parent] is not acting right and stated that he is not feeling well. RN performed PRN [as needed] visit to assess pt." Review of the record failed to evidence the RN notified the physician about the patient's recent emergency department visit.</p> <p>On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p>			

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	<p>10. Clinical record #11, start of care 2/7/13, contained a home health certification and plan of care dated 2/7/13-4/7/13 which states for skilled nursing to notify physician for diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 2/18/13, employee C, Licensed Practical Nurse (LPN), documented a diastolic blood pressure of 50. The record failed to evidence the registered nurse or physician was notified of the low diastolic blood pressure.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>11. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 1/17/13, employee C, LPN,</p>			

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	<p>documented a pulse of 52. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>B. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>D. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>E. On 2/18/13, employee C, LPN, documented a pulse of 55. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>F. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the</p>			

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	<p>record to show physician notification was made.</p> <p>12. Clinical record #16, start of care 2/5/13, contained a home health certification and plan of care dated 2/5/13-4/5/13 which states for skilled nursing to notify physician of any abnormalities. On 2/19/13, employee C, LPN, documented a diastolic blood pressure of 100 and a pulse of 104. The record failed to evidence the registered nurse or physician was notified of the increased diastolic blood pressure and pulse.</p>				

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N000532	<p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure physician was notified regarding changes in the patient's condition for 5 of 16 clinical records reviewed with the potential to affect all patients of the agency. (#3, 5, 11, 12, and 16)</p> <p>Findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client</p>	N000532	<p>410 IAC 17-13-1(d) Patient Care A mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08 Nursing Service-"The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services" Policy #33.17 Medical Supervision-" Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes</p>	04/06/2013			

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	<p>conditions and needs, coordinates care with other disciplines and services."</p> <p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Case Conferences - Coordination of Service" policy number 33.20, revised 8/24/11 states, "Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care."</p> <p>4. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p> <p>5. The policy titled "Apical Pulse" policy number 33.203, revised</p>		<p>in the patients condition as appropriate". Policy 33.20 Case Conferences - Interdisciplinary Group Meeting/Coordination of Services" Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care." Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart." Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care."In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the</p>		

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	<p>6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or abnormalities of rate, rhythm. Document physician notification in patient chart."</p> <p>6. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>7. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>8. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100. Review of the record evidenced the following:</p>		<p>quarterly record review performed by Director of Clinical Services or designee. This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCMClient #3--Physician notified on 3/19/13 of elevated pulse from 2/21/13Client #5--Client discharged on 2/10/13 after hospitalizationClient #11--Client discharged on 2/28/13Client #12--Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, 2/18/13, 2/27/13, and 3/4/13Client #16--Physician notified on 3/19/13 of vitals not within parameters on 2/19/13.</p>	

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	<p>A. On 2/21/13, employee U, Registered Nurse (RN), documented a radial pulse of 105. The record failed to evidence the physician was notified of the increased pulse rate.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>9. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 and included a skilled nursing visit note dated 2/10/13 by employee X, RN, which states, "Pt's [patient's] son took [patient] to ER [Emergency Department] last night. Pt's son stated [patient's] BP [blood pressure] was low ever since [patient] came back from dialysis. Pt was treated and released. Pt's son called RN to check on pt. Pt's son stated his [parent] is not acting right and stated that he is not feeling well. RN performed PRN [as needed] visit to assess pt." Review of the record failed to evidence the RN notified the physician about the patient's recent emergency department visit.</p> <p>On 3/14/13 at 9:40 AM, employee I, administrator, indicated no</p>				

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	<p>documentation was found in the record to show physician notification was made.</p> <p>10. Clinical record #11, start of care 2/7/13, contained a home health certification and plan of care dated 2/7/13-4/7/13 which states for skilled nursing to notify physician for diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 2/18/13, employee C, Licensed Practical Nurse (LPN), documented a diastolic blood pressure of 50. The record failed to evidence the registered nurse or physician was notified of the low diastolic blood pressure.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>11. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of</p>			

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(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	
	<p>the record evidenced the following:</p> <p>A. On 1/17/13, employee C, LPN, documented a pulse of 52. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p> <p>B. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>D. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>E. On 2/18/13, employee C, LPN, documented a pulse of 55. The record failed to evidence the registered nurse or physician was notified of the decreased pulse rate.</p>				

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	<p>F. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>12. Clinical record #16, start of care 2/5/13, contained a home health certification and plan of care dated 2/5/13-4/5/13 which states for skilled nursing to notify physician of any abnormalities. On 2/19/13, employee C, LPN, documented a diastolic blood pressure of 100 and a pulse of 104. The record failed to evidence the registered nurse or physician was notified of the increased diastolic blood pressure and pulse.</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 policy review, clinical record review, and interview, the home health agency failed to ensure skilled nursing visits were made in accordance with the plan of care, treatments were provided as ordered, and physician notification was made as ordered per the plan of care in 7 of 16 records reviewed with the potential to affect all the agency's patients who received skilled nursing services. (#1, 3, 4, 5, 9, 11, and 12).</p> <p>The findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client</p>	N000537	<p>410 IAC 17-14-1(a) Scope of Services A mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08 Nursing Service-"The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services". Policy #33.17 Medical Supervision-" Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as appropriate". Policy # 33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician</p>	04/06/2013

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	<p>conditions and needs, coordinates care with other disciplines and services."</p> <p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>4. Clinical record #1, start of care 11/30/12, contained a home health certification and plan of care dated 11/30/12-1/28/13 with orders for skilled nursing to visit 7 times per week for 2 weeks, 3 times per week for 2 weeks, 2 times per week for 1 week, and 1 times per week for 4 weeks. The record evidenced no skilled nursing visits were made the week of 1/11/13 and 1/18/13.</p>		<p>orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care."Re-education to be provided to clinical staff on documenting a full set of vitals on every visit by Director of Clinical Services on 3/26/13A new process was put into place on 3/11/13 to ensure the physician is notified of all missed visits. Education was given to all clinical staff and schedulers by Director of Clinical Services on 3/12/13. In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee. This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCM Client #1--SN missed visit forms completed and faxed to physician on 3/5/13 Client #3--Physician notified on 3/19/13 of elevated pulse from 2/21/13 Client #4--SN missed visit forms completed and faxed to physician on 3/5/13 Client #5--SN missed visit forms completed and faxed to physician on 3/5/13 Client #9--SN missed visit forms completed and faxed to physician</p>				

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	<p>5. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 with orders for skilled nursing to notify physician for heart rate less than 60 or greater than 100, temperature greater than 100.5 Fahrenheit, and respirations less than 12 or greater than 24. Review of the record evidenced the following:</p> <p>A. On 2/14/13, employee U, Registered Nurse (RN), failed to document the patient's temperature or respirations.</p> <p>B. On 2/19/13, employee U, RN, failed to document the patient's temperature</p> <p>C. On 2/21/13, employee U, RN, documented a radial pulse of 105. The record failed to evidence the physician was notified of the increased pulse rate.</p> <p>D. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>6. Clinical record #4, start of care 11/28/12, contained a home health</p>		<p>on 3/5/13 Client #11--SN missed visit forms completed and faxed to physician on 3/5/13 Client #12--Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, 2/18/13, 2/27/13, and 3/4/13.</p>	

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	<p>certification and plan of care dated 01/27/13-03/27/13 with orders for Skilled Nursing (SN) to visit 1 time per week for 9 weeks. The record evidenced no SN visits were made the week of 1/25/13 and 2/8/13.</p> <p>7. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 with orders for SN to visit 1 time per week for 1 week, 2 times per week for 1 week, and 1 time per week for 7 weeks. The record evidenced only 1 SN visit was made the week of 2/8/13 and no SN visits were made the week of 2/15/13 or 2/22/13.</p> <p>8. Clinical record #9, start of care 1/24/13, contained a home health certification and plan of care dated 1/24/13-3/24/13 with orders for SN 1 time per week for 9 weeks. The record evidenced no SN visits were made the week of 2/1/13.</p> <p>9. Clinical record #11, start of care 2/7/13, contained a home health certification and plan of care dated 2/7/13-4/7/13 with orders for skilled nursing 1 time per week for 1 week, 2 times per week for 2 weeks, and 1 time per week for 2 weeks. The record evidenced only 1 SN visit was</p>			

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	<p>made the week of 2/8/13.</p> <p>10. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 with orders for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>B. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>D. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no</p>				

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	documentation was found in the record to show physician notification was made.				

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N000546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the registered nurse notified the physician of changes in the patient's condition for 3 of 16 clinical records reviewed with the potential to affect all patients of the agency. (#3, 5, and 12)</p> <p>Findings include:</p> <p>1. The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Registered Nurse: Follows a written plan of care established and periodically reviewed by the physician ... promptly alerts the physician to any changes that suggest a need to alter the plan of care ... The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with</p>	N000546	410 IAC 17-14-1(a)(1)(G) Scope of ServicesA mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy 33.08 Nursing Service-"The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services". Policy #33.17 Medical Supervision-" Physicianwill be contacted when any of the following occurs: when client does not meet the criteria	04/06/2013			

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	<p>physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services."</p> <p>2. The policy titled "Medical Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Case Conferences - Coordination of Service" policy number 33.20, revised 8/24/11 states, "agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care."</p> <p>4. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p>		<p>established by the company and their plan of services...of changes in the patients condition as appropriate". Policy # 33.20 Case Conferences - Interdisciplinary Group Meeting/Coordination of Services-"Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care." Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart." Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care."In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical</p>		

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	<p>5. The policy titled "Apical Pulse" policy number 33.203, revised 6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or abnormalities of rate, rhythm. Document physician notification in patient chart."</p> <p>6. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>7. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>8. Clinical record #3, start of care 2/10/13, contained a home health certification and plan of care dated 2/10/13-4/10/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100. Review of the record evidenced</p>		<p>Services/ designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee. This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCMClient #3--Physician notified on 3/19/13 of elevated pulse from 2/21/13. Client #5--Client discharged on 2/10/13 after admission to hospitalClient #12--Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13, 2/18/13, 2/27/13, and 3/4/13.</p>				

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	<p>the following:</p> <p>A. On 2/21/13, employee U, Registered Nurse (RN), documented a radial pulse of 105. The record failed to evidence the physician was notified of the increased pulse rate.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>9. Clinical record #5, start of care 2/6/13, contained a home health certification and plan of care dated 2/6/13-4/6/13 and included a skilled nursing visit note dated 2/10/13 by employee X, RN, which states, "Pt's [patient's] son took [patient] to ER [Emergency Department] last night. Pt's son stated [patient's] BP [blood pressure] was low ever since [patient] came back from dialysis. Pt was treated and released. Pt's son called RN to check on pt. Pt's son stated his [parent] is not acting right and stated that he is not feeling well. RN performed PRN [as needed] visit to assess pt." Review of the record failed to evidence the RN notified the physician about the patient's recent emergency department visit.</p>			
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	<p>On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.</p> <p>10. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 1/19/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>B. On 1/23/13, employee Y, RN, documented a diastolic blood pressure of 56. The record failed to evidence the physician was notified of the decreased diastolic blood pressure.</p> <p>C. On 2/16/13, employee Y, RN, documented a diastolic blood pressure of 58. The record failed to evidence the physician was notified of the decreased diastolic blood</p>			

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	pressure. D. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show physician notification was made.			
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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 policy review, clinical record review, and interview, the home health agency failed to ensure the home health aide plan of care was updated at least every 60 days as required by agency policy and the registered nurse included all relevant information of the home health aide plan of care in 2 of 5 records reviewed of patients receiving home health aide services with the potential to affect all patients receiving home health aide services. (#6 and 12)</p> <p>The findings include:</p> <p>1. The policy titled "Homemaker / Home Health Aide Care Plan and Assignment Sheet" policy number 33.37, with a revision date of 8/25/11 states, "Any client that has a home health aide/homemaker as part of their Plan of Care must have a Home Health Aide/Homemaker Care Plan and Assignment Sheet completed at</p>	N000550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services A mandatory in service will be held 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding Policy #33.37 Care Planning Process-"Any client that has a home health aide/homemaker as part of their plan of care must have a Home Health Aide/Homemaker care plan and assignment sheet completed at the time of admission by the clinicians or whenever there are significant changes in the clients needs or condition but at least annually. Safety/Special Precautions section is individualized according to the care required for each client. This could include falls risk. The assignment sheet is to be reviewed at a minimum of every 60 days or as needed by the clinician. This review is to be documented with date and signature under SPECIFIC INSTRUCTIONS AND DOCUMENTATION section."</p>	04/06/2013	

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	<p>the time of admission by the Clinician or whenever there are significant changes in the client's needs or condition but at least annually ... Safety/Special Precautions section is individualized according to the care required for each client. This could include falls risk ... The assignment sheet is to be reviewed at a minimum of every 60 days or as needed by the Clinician. This review it to be documented with the date and signature under SPECIFIC INSTRUCTIONS AND DOCUMENTATION section."</p> <p>2. Clinical record #6, start of care 6/15/12, contained a home health certification and plan of care dated 2/10/13-4/10/13 and evidenced a Home Health Aide (HHA) care plan that had not been updated every 60 days. The last HHA care plan was dated 10/9/2012.</p> <p>3. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 and evidenced a HHA care plan dated 1/14/13. The care plan had a section titled "Fall Risk" which was blank.</p> <p>A. During a home visit on 3/6/13 at 2:00 PM, patient #12 reported they</p>		<p>In order to show compliance 6 randomly chosen clinical records with home health aide services will audited monthly for 3 months by the Director of Clinical Services / designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or designee.</p> <p>This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCM</p> <p>Client #6--HHA careplan updated on 3/19/13</p> <p>Client #12--HHA careplan updated including falls risk on 3/19/13.</p> <p>All patients receiving home health aide services will have the careplan reviewed/updated by 4/16/2013</p>		

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	<p>fell during a bath while the Home Health Aide (HHA) was there.</p> <p>B. The Skilled Nursing Admission Visit, dated 1/4/13, indicates a fall risk score of 10.</p> <p>C. During an interview on 3/7/13 at 1:10 PM, employee I, Administrator, indicated the HHA care plan should have noted the patient was a fall risk.</p>			

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N000559	<p>410 IAC 17-14-1(a)(2)(G) Scope of Services Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the Licensed Practical Nurse (LPN) notified the registered nurse (RN) of changes in the patient's condition and needs for 3 of 16 clinical records reviewed with the potential to affect all patients of the agency who receive LPN services. (#11, 12, and 16)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Nursing Service" policy number 33.08, revised 4/30/07 states, "The Licensed Practical Nurse: ... Implements the plan of care/service in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciplines and services." The policy titled "Medical 	N000559	<p>410 IAC 17-14-1(a)(2)(G)A mandatory in service will be held on 3/26/13 by the Director of Clinical Services/designee with clinical personnel and information mailed to all clinicians unable to attend by 3/28/13 regarding ANC Policy #33.08 Nursing Service-"The Registered Nurse follows a written plan of care established and periodically reviewed by the physician..promptly alerts the physician to any changes that suggest a need to alter the plan of care....The Licensed Practical Nurse..Implements the plan of care/services in accordance with physician plan of treatment, informs RN supervisor of changes in client conditions and needs, coordinates care with other disciPolicy #33.17 Medical Supervision-" Physician will be contacted when any of the following occurs: when client does not meet the criteria established by the company and their plan of services...of changes in the patients condition as appropriate". Policy # 33.20 Case</p>	04/06/2013

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	<p>Supervision" policy number 33.17, revised 7/18/06 states, "Physician will be contacted when any of the following occurs: ... when the client does not meet the criteria established by the company and their plan of services ... of changes in the patient's condition as appropriate."</p> <p>3. The policy titled "Case Conferences - Coordination of Service" policy number 33.20, revised 8/24/11 states, "Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care."</p> <p>4. The policy titled "Blood pressure" policy number 33.201, revised 6/21/12 states, "When client's baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart."</p> <p>5. The policy titled "Apical Pulse" policy number 33.203, revised 6/21/12 states, "Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or abnormalities of rate, rhythm. Document physician</p>		<p>Conferences - Interdisciplinary Group Meeting/Coordination of Services-"Agency staff regularly communicate to assure that their efforts are coordinated effectively and ultimately support the objectives outlined in the plan of care." Policy #33.201 Blood Pressure-"When clients baseline is unknown, report blood pressure lower than 90/60 or above 140/90 to physician. Notify physician unless otherwise specified. Document physician notification in patient chart." Policy # 33.203 Apical Pulse-"Notify physician of apical pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities of rate, rhythm. Policy #33.204 Radial Pulse-"Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart." Policy #33.24 Plan of Care and Physician Orders-"All care and services provided is according to current physician orders. Clinicians are responsible for alerting the physician to any changes in client care or condition that suggests a need to alter the plan of care."In order to show compliance 6 randomly chosen clinical records will audited monthly for 3 months by the Director of Clinical Services/ designee. Ongoing monitoring will be part of the quarterly record review performed by Director of Clinical Services or</p>				

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	<p>notification in patient chart."</p> <p>6. The policy titled "Radial Pulse" policy number 33.204, revised 6/21/12 states, "Notify physician of radial pulse greater than 100 or less than 60 (unless specified by physician) or any abnormalities. Document physician notification in patient chart."</p> <p>7. The policy titled "Plan of Care and Physician Orders" policy number 33.24, revised 4/28/08 states, "All care and services provided is according to current physician orders. Clinicians are responsible for altering the physician to any changes in client care or condition that suggest a need to alter the plan of care."</p> <p>8. Clinical record #11, start of care 2/7/13, contained a home health certification and plan of care dated 2/7/13-4/7/13 which states for skilled nursing to notify physician for diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 2/18/13, employee C, LPN, documented a diastolic blood pressure of 50. The record failed to evidence the registered nurse was notified of the low diastolic blood</p>		<p>designee. This process will be under the direct supervision of the Director of Operations with oversight by RVP/RCMClient #11--Client discharged on 2/28/13Client #12--Physician notified on 3/19/13 of all vitals not within parameters for dates 1/17/13, 1/19/13, 1/23/13, 2/16/13,2/18/13, 2/27/13, and 3/4/13. Client #16--Physician notified on 3/19/13 of vitals out of parameters on 2/19/13.</p>				

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	<p>pressure.</p> <p>B. On 3/14/13 at 9:40 AM, employee I, administrator, indicated no documentation was found in the record to show the RN was notified.</p> <p>9. Clinical record #12, start of care 1/14/13, contained a home health certification and plan of care dated 1/14/13-3/14/13 which states for skilled nursing to notify physician for heart rate less than 60 or greater than 100, and diastolic blood pressure less than 60 or greater than 90. Review of the record evidenced the following:</p> <p>A. On 1/17/13, employee C, LPN, documented a pulse of 52. The record failed to evidence the registered nurse was notified of the decreased pulse rate.</p> <p>B. On 2/18/13, employee C, LPN, documented a pulse of 55. The record failed to evidence the registered nurse was notified of the decreased pulse rate.</p> <p>C. On 3/14/13 at 1:30 PM, employee I, administrator, indicated no documentation was found in the record to show the registered nurse was notified.</p>						

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	10. Clinical record #16, start of care 2/5/13, contained a home health certification and plan of care dated 2/5/13-4/5/13 which states for skilled nursing to notify physician of any abnormalities. On 2/19/13, employee C, LPN, documented a diastolic blood pressure of 100 and a pulse of 104. The record failed to evidence the registered nurse was notified of the increased diastolic blood pressure and pulse.			