STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157571	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/15/2011
NAME OF PROVIDER OR SUPPLIER CARETENDERS		STREET ADDRESS, CITY, STATE, ZIP CODE 1724 STATE STREET NEW ALBANY, IN47150	

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G0000	This was a home health federal recertification survey. This was a partial extended survey. Facility #: 004701 Survey Dates: 12-13-11, 12-14-11, & 12-15-11 Partial Extended Dates: 12-13-11, 12-14-11, & 12-15-11 Medicaid Vendor: N/A Surveyor: Vicki Harmon, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN December 21, 2011	G0000		
G0108	The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. Based on clinical record review and interview, the agency failed to ensure patients had been informed of the	G0108	The agency Directors/Clinical Managers will conduct an inservice for all staff regarding:The home health	01/14/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	frequency of visits proposed to be furnished in 8 (#s 3, 4, 5, 7, 8, 9, 10, and 11) of 12 records reviewed creating the potential to affect all of the agency's 290 current patients. The findings include: 1. Clinical record number 3 evidenced the physician had ordered skilled nurse (SN) services 2w 1 (2 times per week for 1 week), 3w1 (3 times per week for 1 week), 2w3 (2 times per week for 3 weeks), and 1w4 (1 time per week for 4 weeks) during the certification period 10-19-11 to 12-17-11. The record failed to evidence the patient had been informed of the proposed frequency of SN visits ordered by the physician. 2. Clinical record number 4 evidenced the physician had ordered SN services 2w1, 3w1, 2w5, and 1w2; physical therapy (PT) services 1w1, 2w1, and 3w4; occupational therapy (OT) services 1w1, 1w2, and 2w3; and home health aide services 2w1 and 2w5 during the certification period 11-16-11 to 01-14-12. The record failed to evidence the patient had been informed of the proposed frequency of SN, PT, OT, and home		agency's responsibility to notify the patient in advance of the disciplines to provide care and the proposed frequency of visits.Clinicians will be instructed to document on the admission, evaluation, post hospital assessment or recertification that the patient was advised in advance of the disciplines that will furnish care and the frequency of visits proposed. The management staff will review 100% of admissions, evaluations, post hospital assessments and recertifications to ensure compliance with documentation that the patient was informed of proposed disciplines and frequency of visits.The Director is responsible for the on-going compliance with this requirement and will perform random audits on a monthly basis.1. Clinical Record #3 - SN documented planned frequency of visits with patient.2. Clinical Record #4 - SN documented discussion with patient for proposed visit frequency for nursing, home health aide, OT evaluation and PT evaluation.OT documentation present. (Addendum A). PT documented proposed frequency at time of initial evaluation.3. Clinical Record #5 - PT documentation present. (Addendum B)4. Clinical Record #7 - SN documentation present. (Addendum C) PT documented patient informed of proposed physical therapy frequency on	

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	health aide visits ordered by the physician. 3. Clinical record number 5 evidenced the physician had ordered PT services 1w1 and 3w4 during the certification period 12-02-11 to 01-30-12. The record failed to evidence the patient had been informed of the proposed frequency of PT visits ordered by the physician. 4. Clinical record number 7 evidenced the physician had ordered SN 2w1 and 2w2 and PT 3w1 and 3w2 during the certification period 11-16-11 to 01-14-12. The record failed to evidence the patient had been informed of the proposed frequency of SN and PT visits ordered by the physician. 5. Clinical record number 8 evidenced the physician had ordered PT services 3w1 and 2w3 during the certification period 10-18-11 to 12-16-11. The record failed to evidence the patient had been informed of the proposed frequency of PT visits ordered by the physician. 6. Clinical record number 9 evidenced the physician had ordered SN services		admit.5. Clinical Record #8 - patient discharged from agency on 11/11/11.6. Clinical Record #9 - SN and PT documented planned frequency with patient.7. Clinical Record #10 -patient was discharged 12/15/11.8. Clinical Record #11 -patient was discharged from the agency 9/7/11.	

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	2w1, 2w1, and 1w1, and PT to evaluate then 2w1 and 2w3 during the certification period 11-30-11 to 01-28-12. The record failed to evidence the patient had been informed of the proposed frequency of SN and PT visits ordered by the physician. 7. Clinical record number 10 evidenced the physician had ordered PT services 1w1, 3w2, and 2w2; OT services 1w1, and medical social services (MSS) 1w1. The record failed to evidence the patient had been informed of the proposed frequency of PT, OT, and MSS visits ordered by the physician. 8. Clinical record number 11 evidenced the physician had ordered SN services 1w6 and home health aide services 1w1 and 1w6 during the certification period 8-16-11 to 10-14-11. The record failed to evidence the patient had been informed of the proposed frequency of SN and home health aide visits ordered by the physician. 9. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when			

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	requested on 12-15-11 at 9:20 AM and 12-15-11 at 1:30 PM just prior to the exit conference.			
G0121	The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, interview, and review of agency policy, the agency failed to ensure employees had provided care in accordance with the agency's standard precautions policies and procedures in 3 (employees D, H, I,) of 6 employees observed during home visits creating the potential for the spread of disease causing organisms among all of the agency's 290 current patients and staff. The findings include: 1. The agency's 4-03 "7.4 Standard Precautions" policy states, "All staff will utilize and follow the CDC [Centers for Disease Control] recommended Standard Precautions when providing patient care regardless of the diagnosis or presumed infection status." 2. The CDC "Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" states, "IV. Standard Precautions . . . IV.A. Hand hygiene IV.A.1. During	G0121	The agency Directors/Clinical Managers will conduct an inservice for all staff regarding:The use of Standard Precautions.The Director will distribute and review the agency policy on "Standard Precautions" and "Hand Washing".Twelve home visits will be completed by the management staff in the first quarter 2012 to monitor compliance with Standard Precautions. The results will be reported at the 1st quarter 2012 PI meeting. The Director is responsible for on-going compliance with this requirement and will monitor quarterly as part of the PI Program.	01/14/2012

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	the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . IV.A.3. . . . Perform hand hygiene: . . . IV.3.b. After contact with blood, body fluids, or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse, or blood pressure, or lifting a patient). IV.A.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves." 3. A home visit was completed with employee D, a home health aide, on 12-13-11 at 1:35 PM. The employee was observed to provide a partial bath to patient number 2. The employee donned a clean pair of gloves at the start of the procedure and failed to change her gloves or wash her hands until the procedure had been completed. A. Patient number 2 was observed to be sitting in a chair at the top of the stairs to the second floor of the home. The			

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	walls were unpainted; dust, dirt, and peeling paint were noted on the wooden stairs leading to the second floor. The kitchen and living areas were observed to be cluttered and dusty. There were dirty dished observed in the kitchen sink. B. The employee was observed take the patient's blood pressure, temperature, pulse, and respirations; clean the equipment; and reach into her bag and obtain clean gloves. The employee donned the clean gloves, touched the urinary catheter tubing, and went down the stairs to obtain the bath water. The employee was observed to touch the doorframe to the bathroom and then obtain bath water. The employee went back up the stairs with the water and bath towels. C. The employee removed the blanket from the patient and completed a partial bath by washing the patient's face, hands, and hair. The employee combed the patient's hair. The employee then touched the patient's right foot and noted sediment in the urinary catheter tubing. The employee then replaced the blanket on the patient, carried the water and towels down the stairs and disposed of the bath water in the bathroom. D. The employee retrieved a bath			

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	basin and emptied the foley catheter drainage bag into the basin and disposed the urine in the toilet. The employee then rinsed the basin, removed her gloves, and cleansed her hands. 4. A home visit was completed with employee H, a registered nurse, on 12-13-11 at 3:15 PM. The employee was observed to perform a dressing change on the right foot of patient number 3. The employee failed to cleanse her hands after removing gloves and donning clean ones, failed to cleanse her hands after performing vital signs, and failed to cleanse her hands after performing the wound care and writing on the skilled nurse visit note. A. The employee was observed to take the patient's blood pressure, temperature, pulse, and respirations. The employee then reached into her nursing bag, retrieved clean gloves, and donned the clean gloves without cleansing her hands. B. The employee touched the bottom of the patient's right foot and reached into the patient's bag of dressing change supplies. The employee then opened the supplies, removed her gloves, and donned clean gloves without cleansing her hands. C. The wound did not have a dressing			

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	on it, and the employee cleansed the wound, removed the glove from her left hand, retrieved the bandage scissors, cleaned the scissors, donned a clean glove without cleansing her hands, and applied a dressing to the wound. 5. A home visit was completed with employee I, on 12-14-11 at 9:20 AM, to patient number 1. The employee was observed to perform a dressing change to patient's left leg. The employee was observed to cleanse her hands after taking the patient's vital signs and performing an assessment. The employee reached into the patient's bag of dressing change supplies, retrieved and opened the supplies, and then donned clean gloves without cleansing her hands. 6. The home visit observations were discussed with the administrator, employee E, and supervising nurse, employee F, on 12-15-11 at 1:15 PM. The administrator and supervising nurse agreed employees D, H, and I had not followed the agency's standard precautions policy.			
G0123	Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Based on administrative record review	G0123	The Administrator will update the	01/14/2012

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	and interview, the agency failed to ensure lines of authority down to the patient care level had been defined creating the potential to affect all of the agency's 290 current patients. The findings include: 1. The agency's organizational charts for the parent and branch offices failed to include field staff to include registered and licensed practical nurses, home health aides, therapists, and the medical social worker. 2. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when requested on 12-15-11 at 11:30 AM and at 1:30 PM just prior to the exit conference.		agency organizational charts for the parent and branch locations to include lines of authority for the therapists, nurses, home health aides and medical social workers. Completed 1/6/2012.The organizational chart will be distributed and reviewed with all staff and posted on the bulletin board in each location for reference.The administrator will update the organizational charts with any resignations or new hires where appropriate.The administrator is responsible for on-going compliance with this requirement.	
G0158	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and visits had been provided as ordered on the plan of care in 4 (#s 1, 3, 4, and 7) of 12 records reviewed creating the potential to affect all of the agency's 290 current patients.	G0158	The agency Directors/Clinical Managers will conduct an inservice for all staff regarding:Written plan of care will be followed and documented as ordered by the physician.The Clinical Manager will review all wound care documentation weekly to ensure compliance and	01/14/2012

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	The findings include: 1. Clinical record number 1 included a physician order dated 10-19-11 that states, "Left posterior leg, wound vac @ 125 mm continuous suction with black foam. Place Promogran or equivalent into wound bed under black foam." A. A skilled nurse (SN) visit note dated 10-28-11 failed to evidence the SN had placed the Promogran or equivalent into the wound bed under the black foam. B. The supervising nurse, employee F, indicated, on 12-15-11 at 12:15 PM, the 10-28-11 SN visit note did not evidence the SN had placed the Promogran or equivalent into the wound bed under the black foam as ordered by the physician. 2. Clinical record number 3 included a verbal order dated 10-21-11 that states, "Mental health nurse may eval [evaluate] pt [patient] and a verbal order dated 12-8-11 that states, "MSW [medical social worker] 1w1 Eval & Treat [1 time per week for 1 week to evaluate and treat] effective date 12-10-11. A. The record failed to evidence the patient had been evaluated by the mental health nurse or the medical social worker.		accurate documentation that reflects the plan of care.The Director will distribute and review the agency policy "Assessment/Reassessment" to include the "Procedure for Subsequent Assessments".Clinical Managers are responsible for notifying additional disciplines ordered for a patient and documenting the time and date of notification. Clinical Managers will keep a log of additional disciplines ordered and date the evaluation was completed. The Clinical Manager will ensure documentation is completed if evaluation not done within 48 hours and that the physician was notified.The Clinical Manager will monitor frequency variances weekly and ensure that a missed visit form is completed, sent to the physician and filed in the medical record if visits are not conducted per the plan of care. The Director is responsible for on-going compliance of this regulation and will perform random audits monthly. 1. Clinical Record #1-wound care orders reviewed with RN and re-educated on implementing orders and documenting care as ordered by MD.2. Clinical Record #3 - documentation completed that MSW and mental health nurse evaluations not completed as ordered. MD notification documented. MSW visit completed 12/19/11 and Mental	

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	B. The supervising nurse, employee F, indicated, on 12-15-11 at 12:20 PM, the patient had not yet been evaluated by the mental health nurse of the medical social worker. C. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "Nursing/Psychiatric Nursing initial assessment. Performed by a qualified Registered Nurse within 48 hours of receipt of referral unless otherwise requested by patient / caregiver and/or the physician - ordered start of care." 3. Clinical record number 4 included a plan of care established by the physician for the certification period 11-16-11 to 01-14-12 that identified the patient was to receive SN visits 2 times per week for 1 week, 3 times per week for 1 week, 2 times per week for 5 weeks, and then 1 time per week for 2 weeks effective 11-16-11. A. The record failed to evidence any skilled nurse visits had been provided during week 2, 11-19-11 to 11-25-11. B. The supervising nurse, employee F, stated, on 12-15-11 at 12:30 PM, 'The [skilled nurse] visits were missed."		Health visit performed on 12/22/11 after discharge from acute care facility and new orders obtained.3.Clinical Record #4 - Missed visit records completed for 11/19/11 and 11/25/11 and physician notified.4. Clinical Record #7 - MD order dated 11/15/11 reviewed with RNand re-educated on implementing orders and documenting care as ordered by MD.	

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	C. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "Intermittent Skilled Nursing Visit. Performed by a Registered Nurse or Licensed Practical Nurse as appropriate to the visit . . . Scheduled visit - Performed by the nurse in accordance with the orders." 4. Clinical record number 7 included a plan of care established by the physician for the certification period 11-16-11 to 01-14-12 that states, "Daily wound care to right knee . . . remove staple on 11/28/11, apply steri strips to incision line and leave open to air." A. The skilled nurse visit note dated 11-28-11 failed to evidence the skilled nurse had applied the steri strips to the right knee incision after removing the staples. B. The supervising nurse, employee F, indicated, on 12-15-11 at 9:55 AM, the 11-28-11 skilled nurse visit note did not evidence the skilled nurse had applied the steri strips to the right knee incision after removing the staples.			

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G0164	Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record and agency policy review, the agency failed to ensure the physician had been updated with significant information regarding patients' conditions in 2 (#s 2 and 11) of 12 records reviewed creating the potential to affect all of the agency's 290 current patients. The findings include: 1. A home visit was completed to patient number 2 on 12-13-11 at 1:35 PM. Observation noted the patient was unable to move self, was unable to respond to questions, and required total care. The patient was observed to be sitting in a chair in a room at the top of the stairway to the second floor of the home. A. Clinical record number 2 included a skilled nurse visit note completed by employee J, a licensed practical nurse, on 11-21-11. The note states, "When this nurse arrived pts [patient's] [adult child's spouse] was pulling in - replied [the adult child's spouse] had to go & take care of some business. Pt. was left alone during that time." The note states, "Pt status report to [employee K], RN." B. During an interview with employee	G0164	The agency Directors/Clinical Managers will conduct an inservice for all staff related to:Notification of the physician for any change in the patients condition.The Director will distribute and review the agency process "Physician Notification of Patient Condition Change". A sign in sheet will be provided as proof of education.The Clinical Manager/Director will ensure coordination of care between disciplines, physicians and health care providers as evidenced by documentation of case conferences at start of care and at least every 60 days or as the patients condition warrants.To ensure ongoing compliance, as part of the Quarterly Utilization Review, 10% sample of medical records will be audited. Results will be reported at the 1st Quarter PI meeting.The Director is responsible for on-going compliance with this requirement which will be monitored with the quarterly PI medical record review process.1. Clinical Record #2 (D) - RN documented notification of MD as discussed in interview with surveyor.2. Clinical Record #11 - Patient discharged from agency 9/7/11. No further follow up.	01/14/2012

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	J, on 12-15-11 at 8:15 AM, the employee stated, "I was concerned. That's why I told the RN." C. The record failed to evidence the RN had reported the potential danger to the patient in the event of a fire or other disaster to the physician. D. During an interview with the RN, employee K, on 12-15-11 at 8:15 AM, the employee stated, "I did report it to the Dr.'s office. It is not documented." The RN also indicated she had not informed the physician of the possible need for a medical social services referral. The RN stated, "The [adult child's spouse] would not be receptive to a social worker." 2. Clinical record number 11 included a plan of care established by the physician for the certification period 08-16-11 to 10-14-11. The record identified the patient had a pertinent diagnosis of diabetes mellitus type II. The record failed to evidence the registered nurse had informed the physician of the patient's high blood sugar readings. A. The record included a skilled nurse visit note, completed by the registered nurse, employee H, on 8-24-11, that evidenced the patient's blood sugar reading was 300. (Desirable blood sugar			

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	reading is 70 to 110). The visit note failed to evidence the nurse had notified the physician of the patient's high blood sugar reading. B. A "Progress/Communication Note" completed by employee L, a registered nurse, on 8-31-11 at 2:00 PM states, "Rec'd [received] call from HHA [home health aide] . . . while at the home of [patient number 11]. [The patient] reports had fallen or passed out & EMS was called. [The patient's] blood sugar upon arrival of EMS was greater than 500." The note identifies the nurse had the home health aide check the blood sugar again at 2:10 PM and the reading was 385. The note indicates the physician was called but was not in the office and "will be back to office in approximately 30 minutes & this note will be faxed to office for MD's review." The record failed to evidence the nurse had ensured the physician was aware of the patient's high blood sugar readings. C. A skilled nurse visit note, completed by employee H, a registered nurse, on 9-1-11 evidenced the patient's blood sugar was 573 at 9:12 AM and 423 at 12 noon. The record failed to evidence the nurse had informed the physician of			

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	the patient's high blood sugar readings. D. The record included a "Missed/Reduced Visit Communication Form" dated 9-7-11 that identified a skilled nurse visit had been missed on 9-7-11 due to "Patient has physician's appointment, then admitted to hospital." E. The record included a transfer comprehensive assessment dated 9-7-11 that identified the patient had been transferred to an inpatient facility for emergent care due to "Hypo/Hyperglycemia, diabetes out of control." F. The supervising nurse, employee F, indicated, on 12-15-11 at 1:25 PM, the record did not evidence the nurse had followed up with the physician on 8-31-11 or had notified the physician of the high blood sugar readings on 9-1-11. 3. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "The results of all assessments are communicated to the patient and as applicable, their caregiver, other healthcare providers, and physician."			
G0170	The HHA furnishes skilled nursing services in accordance with the plan of care.			

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	Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and visits had been provided as ordered on the plan of care in 4 (#s 1, 3, 4, and 7) of 12 records reviewed. The findings include: 1. Clinical record number 1 included a physician order dated 10-19-11 that states, "Left posterior leg, wound vac @ 125 mm continuous suction with black foam. Place Promogran or equivalent into wound bed under black foam." A. A skilled nurse (SN) visit note dated 10-28-11 failed to evidence the SN had placed the Promogran or equivalent into the wound bed under the black foam. B. The supervising nurse, employee F, indicated, on 12-15-11 at 12:15 PM, the 10-28-11 SN visit note did not evidence the SN had placed the Promogran or equivalent into the wound bed under the black foam as ordered by the physician. 2. Clinical record number 3 included a verbal order dated 10-21-11 that states, "Mental health nurse may eval [evaluate] pt [patient] and a verbal order dated 12-8-11 that states, "MSW [medical social worker] 1w1 Eval & Treat [1 time	G0170	The agency Directors/Clinical Managers will conduct an inservice for all staff regarding:Written plan of care will be followed and documented as ordered by the physician.The Clinical Manager will review all wound care documentation weekly to ensure compliance and accurate documentation that reflects the plan of care.The Director will distribute and review the agency policy "Assessment/Reassessment" to include the "Procedure for Subsequent Assessments".Clinical Managers are responsible for notifying additional disciplines ordered for a patient and documenting the time and date of notification. Clinical Managers will keep a log of additional disciplines ordered and date the evaluation was completed. The Clinical Manager will ensure documentation is completed if evaluation not done within 48 hours and that the physician was notified.The Clinical Manager will monitor frequency variances weekly and ensure that a missed visit form is completed, sent to the physician and filed in the medical record if visits are not conducted per the plan of care. The Director is responsible for on-going compliance of this regulation and will perform random audits monthly. 1. Clinical Record #1-wound care orders reviewed with RN and	01/14/2012

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	per week for 1 week to evaluate and treat] effective date 12-10-11. A. The record failed to evidence the patient had been evaluated by the mental health nurse or the medical social worker. B. The supervising nurse, employee F, indicated, on 12-15-11 at 12:20 PM, the patient had not yet been evaluated by the mental health nurse of the medical social worker. C. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "Nursing/Psychiatric Nursing initial assessment. Performed by a qualified Registered Nurse within 48 hours of receipt of reverral unless otherwise requested by patient/caregiver and/or the physician-ordered start of care." 3. Clinical record number 4 included a plan of care established by the physician for the certification period 11-16-11 to 01-14-12 that identifies the patient was to receive SN visits 2 times per week for 1 week, 3 times per week for 1 week, 2 times per week for 5 weeks, and then 1 time per week for 2 weeks effective 11-16-11. A. The record failed to evidence any		re-educated on implementing orders and documenting care as ordered by MD.2. Clinical Record #3 - documentation completed that MSW and mental health nurse evaluations not completed as ordered. MD notification documented. MSW visit completed 12/19/11 and Mental Health visit performed on 12/22/11 after discharge from acute care facility and new orders obtained.3.Clinical Record #4 - Missed visit records completed for 11/19/11 and 11/25/11 and physician notified.4. Clinical Record #7 - MD order dated 11/15/11 reviewed with RNand re-educated on implementing orders and documenting care as ordered by MD.	

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	skilled nurse visits had been provided during week 2, 11-19-11 to 11-25-11. B. The supervising nurse, employee F, stated, on 12-15-11 at 12:30 PM, 'The [skilled nurse] visits were missed." C. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "Intermittent Skilled Nursing Visit. Performed by a Registered Nurse or Licensed Practical Nurse as appropriate to the visit . . . Scheduled visit - Performed by the nurse in accordance with the orders." 4. Clinical record number 7 included a plan of care established by the physician for the certification period 11-16-11 to 01-14-12 that states, "Daily wound care to right knee . . . remove staple on 11/28/11, apply steri strips to incision line and leave open to air." A. The skilled nurse visit note dated 11-28-11 failed to evidence the skilled nurse had applied the steri strips to the right knee incision after removing the staples. B. The supervising nurse, employee F, indicated, on 12-15-11 at 9:55 AM, the 11-28-11 skilled nurse visit note did not			

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	evidence the skilled nurse had applied the steri strips to the right knee incision after removing the staples.			
G0176	The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record and agency policy review, the agency failed to ensure the physician had been updated with significant information regarding patients' conditions in 2 (#s 2 and 11) of 12 records reviewed creating the potential to affect all of the agency's 290 current patients. The findings include: 1. A home visit was completed to patient number 2 on 12-13-11 at 1:35 PM. Observation noted the patient was unable to move self, was unable to respond to questions, and required total care. The patient was observed to be sitting in a chair in a room at the top of the stairway to the second floor of the home. A. Clinical record number 2 included a skilled nurse visit note completed by employee J, a licensed practical nurse, on 11-21-11. The note states, "When this nurse arrived pts [patient's] [adult child's spouse] was pulling in - replied [the adult child's spouse] had to go & take care of	G0176	The agency Directors/Clinical Managers will conduct an inservice for all staff related to:Notification of the physician for any change in the patients condition.The Director will distribute and review the agency process "Physician Notification of Patient Condition Change". A sign in sheet will be provided as proof of education.The Clinical Manager/Director will ensure coordination of care between disciplines, physicians and health care providers as evidenced by documentation of case conferences at start of care and at least every 60 days or as the patients condition warrants.To ensure ongoing compliance, as part of the Quarterly Utilization Review, 10% sample of medical records will be audited. Results will be reported at the 1st Quarter PI meeting.The Director is responsible for on-going compliance with this requirement which will be monitored with the quarterly PI medical record review process.1. Clinical Record #2 (D) - RN documented notification of MD as discussed in interview with surveyor.2. Clinical	01/14/2012

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	some business. Pt. was left alone during that time." The note states, "Pt status report to [employee K], RN." B. During an interview with employee J, on 12-15-11 at 8:15 AM, the employee stated, "I was concerned. That's why I told the RN." C. The record failed to evidence the RN had reported the potential danger to the patient in the event of a fire or other disaster to the physician. D. During an interview with the RN, employee K, on 12-15-11 at 8:15 AM, the employee stated, "I did report it to the Dr.'s office. It is not documented." The RN also indicated she had not informed the physician of the possible need for a medical social services referral. The RN stated, "The [adult child's spouse] would not be receptive to a social worker." 2. Clinical record number 11 included a plan of care established by the physician for the certification period 08-16-11 to 10-14-11. The record identified the patient had a pertinent diagnosis of diabetes mellitus type II. The record failed to evidence the registered nurse had informed the physician of the patient's high blood sugar readings.		Record #11 - Patient discharged from agency 9/7/11. No further follow up.	

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	A. The record included a skilled nurse visit note, completed by the registered nurse, employee H, on 8-24-11, that evidenced the patient's blood sugar reading was 300. (Desirable blood sugar reading is 70 to 110). The visit note failed to evidence the nurse had notified the physician of the patient's high blood sugar reading. B. A "Progress/Communication Note" completed by employee L, a registered nurse, on 8-31-11 at 2:00 PM states, "Rec'd [received] call from HHA [home health aide] . . . while at the home of [patient number 11]. [The patient] reports had fallen or passed out & EMS was called. [The patient's] blood sugar upon arrival of EMS was greater than 500." The note identifies the nurse had the home health aide check the blood sugar again at 2:10 PM and the reading was 385. The note indicates the physician was called but was not in the office and "will be back to office in approximately 30 minutes & this note will be faxed to office for MD's review." The record failed to evidence the nurse had ensured the physician was aware of the patient's high blood sugar readings. C. A skilled nurse visit note,			

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	completed by employee H, a registered nurse, on 9-1-11 evidenced the patient's blood sugar was 573 at 9:12 AM and 423 at 12 noon. The record failed to evidence the nurse had informed the physician of the patient's high blood sugar readings. D. The record included a "Missed/Reduced Visit Communication Form" dated 9-7-11 that identified a skilled nurse visit had been missed on 9-7-11 due to "Patient has physician's appointment, then admitted to hospital." E. The record included a transfer comprehensive assessment dated 9-7-11 that identified the patient had been transferred to an inpatient facility for emergent care due to "Hypo/Hyperglycemia, diabetes out of control." F. The supervising nurse, employee F, indicated, on 12-15-11 at 1:25 PM, the record did not evidence the nurse had followed up with the physician on 8-31-11 or had notified the physician of the high blood sugar readings on 9-1-11. 3. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit) policy states, "The results of all assessments are communicated to the patient and as			

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	applicable, their caregiver, other healthcare providers, and physician."			
G0186	The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) Based on clinical record and agency policy review and interview, the agency failed to ensure therapists had assisted the physician in evaluating patients as ordered in 2 (#s 6 and 10) of 8 records reviewed of patients that received therapy services creating the potential to affect all patients that received therapy from the agency. The findings include: 1. The agency's undated "Summary of Therapy Documentation Requirements" policy states, "An evaluation is completed within 48 hours of receipt of the therapy referral order." 2. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "The Physical, occupational, or Speech Therapist and/or a Medical Social Worker will perform the evaluation visit within 48 hours of receipt of referral unless otherwise requested by the patient/caregiver and/or the physician-ordered start of care."	G0186	The agency Directors/Clinical Managers will conduct an inservice for all staff regarding:Timeliness of assessment and subsequent assessments.The Director will distribute and review the agency policy "Assessment/Reassessment" to include the "Procedure for Subsequent Assessments".Clinical Managers are responsible for notifying additional disciplines ordered for a patient and documenting the time and date of notification. Clinical Managers will keep a log of additional disciplines ordered and date the evaluation was completed. The Clinical Manager will ensure documentation is completed and if evaluation not done within 48 hours, that the physician was notified.The Director is responsible for on-going compliance of this regulation and will perform random audits monthly. 1. Clinical Record #6 - documentation completed addressing PT and OT evaluations not completed in 48 hours and MD notification.2.Clinical Record #	01/14/2012

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	3. Clinical record number 6 included a plan of care established by the physician for the certification period 10-21-11 to 12-19-11 that states, "PT 1W1 [physical therapy 1 time per week for 1 week] effective 10-22-11. OT [occupational therapy] 1W1 effective 10-22-11." A. The record evidenced the PT evaluation had not been completed until 10-25-11. B. The record evidenced the OT evaluation had not been completed until 10-27-11. C. The supervising nurse, employee F, stated, on 12-15-11 at 12:35 PM, "There is no documentation why the OT and the PT did not [complete the evaluations] within 48 hours." 4. Clinical record number 10 included a plan of care established by the physician for the certification period 10-20-11 to 12-18-11 that states, "OT 1W1 effective 10-22-11, MSW [medical social worker] 1W1 effective 10-22-11." A. The record evidenced the OT evaluation had not been completed until 10-25-11.		10- patient was discharged from agency 10/19/11.	

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	B. The supervising nurse, employee F, stated, on 12-15-11 at 1:30 PM, "The OT evaluation was not completed within 48 hours per our policy." 5. The supervising nurse, employee F, stated, on 12-14-11 at 3:15 PM, "The therapists are to make the initial visit within 48 hours unless Dr. orders specify a different date."			
G0212	The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. Based on personnel file and clinical record review and interview, the agency failed to ensure the home health aide had been evaluated for competency in the performance of a task the agency asked the aide to perform in 1 (file D) of 1 file of a home health aide hired prior to the last survey on 12-09-08 creating the potential to affect all patients that receive home health aide services from the agency. The findings include: 1. Clinical record number 11 included a "Home Health Aide Visit Note" signed and dated by employee D, a home health aide, on 8-31-11 that identified the home health aide was in the patient's home and	G0212	The agency Directors/Clinical Managers will conduct an inservice to all staff related to:Scope of service and competency evaluation for a Home Health AideThe Director will distribute and review the agency process "Home Health Aide Services-Tasks the Aide Can and Cannot Perform" along with the Skills Competency Checklist for Home Health Aides. A sign in sheet will be utilized as evidence education has occurred.The Director will provide documentation that both the Aide and Clinical Manager involved have been re-educated and understand the tasks the Home Health Aide can and cannot perform.10% of medical record audits will be conducted quarterly as part of the PI program to ensure ongoing compliance.The	01/14/2012

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	the patient had "passed out" possibly due to an elevated blood sugar. The note states, "Called manager was told to take BS [blood sugar] again it was 349." A. The record included a "Progress/Communication Note" signed and dated by employee L, a registered nurse, on 8-31-11. The note states, "Clinical Manager spoke with [patient number 11] while HHA [home health aide] re-checked the blood sugar." B. Personnel file D failed to evidence the home health aide had received training in the use of a glucometer to check the patient's blood sugar or had been evaluated for competence in the performance of the use of a glucometer. 2. The supervising nurse, employee F, stated, on 12-15-11 at 11:35 AM, "There is no training or competency evaluation for the glucometer for [employee D]."		Director is responsible for on-going compliance of this regulation and will monitor quarterly as part of the PI program.	
G0217	The competency evaluation must be performed by a registered nurse. The in-service training generally must be supervised by a registered nurse who possesses a minimum of 2 years of nursing experience at least 1 year of which must be in the provision of home health care. Based on personnel file review and interview, the agency failed to ensure the registered nurse (RN) had completed the	G0217	The agency Directors will conduct an inservice for the Clinical Managers related to:Competency evaluation for a Home Health	01/14/2012

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	administration of competency evaluations in their entirety in 3 (files A, B, and C) of 3 home health aide files reviewed of aides hired since the last survey on 12-09-08 creating the potential to affect all of patients that receive home health aide services. The findings include: 1. Personnel file A evidenced the individual had been hired on 5-5-10 to provide home health aide on behalf of the agency. The file failed to evidence the RN had administered the competency evaluation in its entirety. A. The file included a form that identified skills to be demonstrated to determine the aide's competency. The form failed to evidence the RN had determined the aide was competent to perform 484.36(a)(1)(xi) normal range of motion and positioning and 484.36(a)(1)(xi)(F) toileting and elimination. B. The form evidenced the aide's competency in the performance of these skills had been determined by employee D, another home health aide. 2. Personnel file B evidenced the individual had been hired on 8-10-11 to provide home health aide services on		AideThe Director will distribute and review the agency's Skills Competency Checklist for Home Health Aides. A sign in sheet will be utilized as evidence education has occurred.All current Home Health Aide's competency checklist will be reviewed and skill competency's completed by an RN. The Director will review for completeness.To ensure ongoing compliance with this requirement, the Director will review and approve all Home Health Aide skills competency checklist prior to any hands on care being provided to a patient.	

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	behalf of the agency. The file failed to evidence the RN had administered the competency evaluation in its entirety. A. The file included a form that identified skills to be demonstrated to determine the aide's competency. The form failed to evidence the RN had determined the aide was competent to perform 484.36(1)(a)(ix)(A) bed bath, 484.36(1)(a)(ix)(D) nail and skin care, 484.36(1)(a)(ix)(E) oral hygiene, and 484.36(1)(a)(x) safe transfer techniques and ambulation, 484.36(1)(a)(xi) normal range of motion and positioning. B. The form evidenced the aide's competency in the performance of these skills had been determined by employee D, another home health aide. 3. Personnel file C evidenced the individual had been hired on 8-10-11 to provide home health aide services on behalf of the agency. The file failed to evidence the RN had administered the competency evaluation in its entirety. A. The file included a form that identified skills to be demonstrated to determine the aide's competency. The form failed to evidence the RN had determined the aide was competent to perform 484.36(1)(a)(iii) reading and			

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	recording of temperature, pulse, and respiration; 484.36(1)(a)(ix)(A) bed bath, (B) sponge, tub, or shower bath, (C) shampoo, sink, tub, or bed (D) nail and skin care (E) oral hygiene (F) toileting and elimination; 484.36(1)(a)(x) safe transfer techniques and ambulation; and 484.36(1)(a)(xi) normal range of motion and positioning. B. The form evidenced the aide's competency in the performance of these skills had been determined by employees A and D, other home health aides. 4. The supervising nurse, employee F, stated, on 12-15-11 at 11:15 AM, "The aides go out into the home with preceptors [other aides] and start doing tasks. After their orientation is complete then the aide is checked off by the RN and goes out independently."			
G0224	Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had prepared the written instructions for the home health aide in 1 (# 12) of 5 records reviewed of patients that received home health aide	G0224	The agency Director/Clinical Managers will conduct an inservice to all staff related to:Medicare standard 484.36-"Written patient care instructions for the home health aide must be prepared by the	01/14/2012

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	services creating the potential to affect all patients that received home health aide services. The findings include: 1. Clinical record number 12 evidenced the patient had received skilled nursing; physical, occupational, and speech therapy services; as well home health aide services, during the certification period 7-27-11 to 9-24-11. The record evidenced a start of care date of 7-27-11 with occupational and speech therapy added effective 7-30-11. The record included a "Home Health Aide Assignment" sheet signed and dated by the occupational therapist on 8-4-11. The record failed to evidence the RN had prepared the written instructions for the home health aide. 2. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when requested on 12-15-11 at 11:30 AM and at 1:30 PM just prior to the exit conference.		registered nurse or other appropriate professional who is responsible for supervision of the home health aide."A sign in sheet will be utilized as proof of education.To ensure ongoing compliance, 10% of medical records will be audited quarterly as part of the Performance Improvement process. Results will be reported at the 1st quarter 2012 PI meeting.The Director is responsible for ongoing compliance and will monitor quarterly as part of the PI program.1. Clinical Record #12-patient discharged from agency 9/24/11.	

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G0228	If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had performed supervisory visits in 1 (# 12) of 5 records reviewed of patients that had received home health aide services creating the potential to affect all patients that received home health aide services. The findings include: 1. Clinical record number 12 evidenced the patient had received skilled nursing; physical, occupational, and speech therapy services; as well home health aide services, during the certification period 7-27-11 to 9-24-11. The record evidenced a start of care date of 7-27-11 with occupational and speech therapy added effective 7-30-11. A. The record evidenced one supervisory visit, completed by the occupational therapist, on 8-10-11. B. The record failed to evidence any	G0228	The agency Directors/Clinical Managers will conduct an inservice regarding:Medicare standard 484.36(d)(1)-If a patient receives skilled nursing care, the registered nurse must perform the supervisory visit. If the patient is not receiving skilled nursing care, but is receiving another skilled service (physical therapy, occupational therapy or speech therapy), supervision may be provided by the appropriate therapist.The Director will distribute and review the Medicare standard and the agency process "Home Health Aide Supervisory Visit Guidelines". A sign in sheet will be utilized as proof of education.An addition will be added to the weekly schedules to prompt the RN, PT, OT or ST to enter the date a supervisory visit is due.To ensure ongoing compliance, 10% of medical records will be audited quarterly as part of the Performance Improvement process. Results will be reported at the 1st quarter 2012 PI meeting.The Director is responsible for ongoing compliance and will monitor	01/14/2012

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	home health aide supervisory visit had been completed by the RN. 2. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when requested on 12-15-11 at 11:30 AM and at 1:30 PM just prior to the exit conference. 3. The agency's undated "HHA Supervisory Visit Guidelines" policy states, "Medicare requires an RN or Qualified Therapist perform and document a supervisory visit at least every 2 weeks (14 days minimally) when HHA services are ordered."		quarterly as part of the PI program.	
G0229	The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had performed supervisory visits in 1 (# 12) of 5 records reviewed of patients that had received home health aide services creating the potential to affect all patients that received home health aide services. The findings include: 1. Clinical record number 12 evidenced	G0229	The agency Directors/Clinical Managers will conduct an inservice regarding:Guidelines for Home Health Aide SupervisionThe Director will distribute and review the agency process "Home Health Aide Supervisory Visit Guidelines" which states that "Medicare requires an RN or Qualified Therapist perform and document a supervisory visit at least every 2 weeks (14 days minimally) when HHA services are ordered". A sign in sheet will be utilized as	01/14/2012

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	the patient had received skilled nursing, physical, occupational, and speech therapy services, as well home health aide services, during the certification period 7-27-11 to 9-24-11. The record evidenced a start of care date of 7-27-11 with occupational and speech therapy added effective 7-30-11. A. The record evidenced one supervisory visit, completed by the occupational therapist, on 8-10-11. B. The record failed to evidence any home health aide supervisory visit had been completed by the RN. 2. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when requested on 12-15-11 at 11:30 AM and at 1:30 PM just prior to the exit conference. 3. The agency's undated "HHA Supervisory Visit Guidelines" policy states, "Medicare requires an RN or Qualified Therapist perform and document a supervisory visit at least every 2 weeks (14 days minimally) when HHA services are ordered."		proof of education.To ensure ongoing compliance, 10% of medical records will be audited quarterly as part of the Performance Improvement process. Results will be reported at the 1st quarter 2012 PI meeting.The Director is responsible for ongoing compliance and will monitor quarterly as part of the PI program.	

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N0440	Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on administrative record review and interview, the agency failed to ensure lines of authority down to the patient care level had been defined creating the potential to affect all of the agency's 290 current patients. The findings include: 1. The agency's organizational charts for the parent and branch offices failed to include field staff to include registered and licensed practical nurses, home health aides, therapists, and the medical social worker. 2. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when requested on 12-15-11 at 11:30 AM and at 1:30 PM just prior to the exit conference.	N0440	The Administrator will update the agency organizational charts for the parent and branch locations to include lines of authority for the therapists, nurses, home health aides and medical social workers. Completed 1/6/2012.The organizational chart will be distributed and reviewed with all staff and posted on the bulletin board in each location for reference.The administrator will update the organizational charts with any resignations or new hires where appropriate.The administrator is responsible for on-going compliance with this rule.	01/14/2012
N0470	Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, interview, and	N0470	The agency Directors/Clinical	01/14/2012

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	review of agency policy, the agency failed to ensure employees had provided care in accordance with the agency's standard precautions policies and procedures in 3 (employees D, H, I,) of 6 employees observed during home visits creating the potential for the spread of disease causing organisms among all of the agency's 290 current patients and staff. The findings include: 1. The agency's 4-03 "7.4 Standard Precautions" policy states, "All staff will utilize and follow the CDC [Centers for Disease Control] recommended Standard Precautions when providing patient care regardless of the diagnosis or presumed infection status." 2. The CDC "Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" states, "IV. Standard Precautions . . . IV.A. Hand hygiene IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . IV.A.3. . . . Perform hand hygiene: . . . IV.3.b. After contact with blood, body fluids, or excretions, mucous		Managers will conduct an inservice for all staff regarding:The use of Standard Precautions.The Director will distribute and review the agency policy on "Standard Precautions" and "Hand Washing".Twelve home visits will be completed by the management staff in the first quarter 2012 to monitor compliance with Standard Precautions. The results will be reported at the 1st quarter 2012 PI meeting. The Director is responsible for on-going compliance with this rule and will monitor quarterly as part of the PI Program.	

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	membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse, or blood pressure, or lifting a patient). IV.A.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves." 3. A home visit was completed with employee D, a home health aide, on 12-13-11 at 1:35 PM. The employee was observed to provide a partial bath to patient number 2. The employee donned a clean pair of gloves at the start of the procedure and failed to change her gloves or wash her hands until the procedure had been completed. A. Patient number 2 was observed to be sitting in a chair at the top of the stairs to the second floor of the home. The walls were unpainted; dust, dirt, and peeling paint were noted on the wooden stairs leading to the second floor. The kitchen and living areas were observed to be cluttered and dusty. There were dirty dished observed in the kitchen sink. B. The employee was observed take the patient's blood pressure, temperature,			

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	pulse, and respirations; clean the equipment; and reach into her bag and obtain clean gloves. The employee donned the clean gloves, touched the urinary catheter tubing, and went down the stairs to obtain the bath water. The employee was observed to touch the doorframe to the bathroom and then obtain bath water. The employee went back up the stairs with the water and bath towels. C. The employee removed the blanket from the patient and completed a partial bath by washing the patient's face, hands, and hair. The employee combed the patient's hair. The employee then touched the patient's right foot and noted sediment in the urinary catheter tubing. The employee then replaced the blanket on the patient, carried the water and towels down the stairs and disposed of the bath water in the bathroom. D. The employee retrieved a bath basin and emptied the foley catheter drainage bag into the basin and disposed the urine in the toilet. The employee then rinsed the basin, removed her gloves, and cleansed her hands. 4. A home visit was completed with employee H, a registered nurse, on 12-13-11 at 3:15 PM. The employee was			

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	observed to perform a dressing change on the right foot of patient number 3. The employee failed to cleanse her hands after removing gloves and donning clean ones, failed to cleanse her hands after performing vital signs, and failed to cleanse her hands after performing the wound care and writing on the skilled nurse visit note. A. The employee was observed to take the patient's blood pressure, temperature, pulse, and respirations. The employee then reached into her nursing bag, retrieved clean gloves, and donned the clean gloves without cleansing her hands. B. The employee touched the bottom of the patient's right foot and reached into the patient's bag of dressing change supplies. The employee then opened the supplies, removed her gloves, and donned clean gloves without cleansing her hands. C. The wound did not have a dressing on it, and the employee cleansed the wound, removed the glove from her left hand, retrieved the bandage scissors, cleaned the scissors, donned a clean glove without cleansing her hands, and applied a dressing to the wound. 5. A home visit was completed with employee I, on 12-14-11 at 9:20 AM, to			

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	patient number 1. The employee was observed to perform a dressing change to patient's left leg. The employee was observed to cleanse her hands after taking the patient's vital signs and performing an assessment. The employee reached into the patient's bag of dressing change supplies, retrieved and opened the supplies, and then donned clean gloves without cleansing her hands. 6. The home visit observations were discussed with the administrator, employee E, and supervising nurse, employee F, on 12-15-11 at 1:15 PM. The administrator and supervising nurse agreed employees D, H, and I had not followed the agency's standard precautions policy.			
N0504	Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on clinical record review and interview, the agency failed to ensure patients had been informed of the	N0504	The agency Directors/Clinical Managers will conduct an inservice for all staff regarding:The home health	01/14/2012

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	frequency of visits proposed to be furnished in 8 (#s 3, 4, 5, 7, 8, 9, 10, and 11) of 12 records reviewed creating the potential to affect all of the agency's 290 current patients. The findings include: 1. Clinical record number 3 evidenced the physician had ordered skilled nurse (SN) services 2w 1 (2 times per week for 1 week), 3w1 (3 times per week for 1 week), 2w3 (2 times per week for 3 weeks), and 1w4 (1 time per week for 4 weeks) during the certification period 10-19-11 to 12-17-11. The record failed to evidence the patient had been informed of the proposed frequency of SN visits ordered by the physician. 2. Clinical record number 4 evidenced the physician had ordered SN services 2w1, 3w1, 2w5, and 1w2; physical therapy (PT) services 1w1, 2w1, and 3w4; occupational therapy (OT) services 1w1, 1w2, and 2w3; and home health aide services 2w1 and 2w5 during the certification period 11-16-11 to 01-14-12. The record failed to evidence the patient had been informed of the proposed frequency of SN, PT, OT, and home		agency's responsibility to notify the patient in advance of the disciplines to provide care and the proposed frequency of visits.Clinicians will be instructed to document on the admission, evaluation, post hospital assessment or recertification that the patient was advised in advance of the disciplines that will furnish care and the frequency of visits proposed. The management staff will review 100% of admissions, evaluations, post hospital assessments and recertifications to ensure compliance with documentation that the patient was informed of proposed disciplines and frequency of visits.The Director is responsible for the on-going compliance with this requirement and will perform random audits on a monthly basis.1. Clinical Record #3 - SN documented planned frequency of visits with patient.2. Clinical Record #4 - SN documented discussion with patient for proposed visit frequency for nursing, home health aide, OT evaluation and PT evaluation.OT documentation present. (Addendum A). PT documented proposed frequency at time of initial evaluation.3. Clinical Record #5 - PT documentation present. (Addendum B)4. Clinical Record #7 - SN documentation present. (Addendum C) PT documented patient informed of proposed physical therapy frequency on	

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	health aide visits ordered by the physician. 3. Clinical record number 5 evidenced the physician had ordered PT services 1w1 and 3w4 during the certification period 12-02-11 to 01-30-12. The record failed to evidence the patient had been informed of the proposed frequency of PT visits ordered by the physician. 4. Clinical record number 7 evidenced the physician had ordered SN 2w1 and 2w2 and PT 3w1 and 3w2 during the certification period 11-16-11 to 01-14-12. The record failed to evidence the patient had been informed of the proposed frequency of SN and PT visits ordered by the physician. 5. Clinical record number 8 evidenced the physician had ordered PT services 3w1 and 2w3 during the certification period 10-18-11 to 12-16-11. The record failed to evidence the patient had been informed of the proposed frequency of PT visits ordered by the physician. 6. Clinical record number 9 evidenced the physician had ordered SN services		admit.5. Clinical Record #8 - patient discharged from agency on 11/11/11.6. Clinical Record #9 - SN and PT documented planned frequency with patient.7. Clinical Record #10 -patient was discharged 12/15/11.8. Clinical Record #11 -patient was discharged from the agency 9/7/11.	

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	2w1, 2w1, and 1w1, and PT to evaluate then 2w1 and 2w3 during the certification period 11-30-11 to 01-28-12. The record failed to evidence the patient had been informed of the proposed frequency of SN and PT visits ordered by the physician. 7. Clinical record number 10 evidenced the physician had ordered PT services 1w1, 3w2, and 2w2; OT services 1w1, and medical social services (MSS) 1w1. The record failed to evidence the patient had been informed of the proposed frequency of PT, OT, and MSS visits ordered by the physician. 8. Clinical record number 11 evidenced the physician had ordered SN services 1w6 and home health aide services 1w1 and 1w6 during the certification period 8-16-11 to 10-14-11. The record failed to evidence the patient had been informed of the proposed frequency of SN and home health aide visits ordered by the physician. 9. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when			

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	requested on 12-15-11 at 9:20 AM and 12-15-11 at 1:30 PM just prior to the exit conference.			
N0522	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: Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and visits had been provided as ordered on the plan of care in 4 (#s 1, 3, 4, and 7) of 12 records reviewed. The findings include: 1. Clinical record number 1 included a physician order dated 10-19-11 that states, "Left posterior leg, wound vac @ 125 mm continuous suction with black foam. Place Promogran or equivalent into wound bed under black foam." A. A skilled nurse (SN) visit note dated 10-28-11 failed to evidence the SN had placed the Promogran or equivalent into the wound bed under the black foam. B. The supervising nurse, employee F, indicated, on 12-15-11 at 12:15 PM, the 10-28-11 SN visit note did not evidence the SN had placed the Promogran or equivalent into the wound bed under the	N0522	The agency Directors/Clinical Managers will conduct an inservice for all staff regarding:Written plan of care will be followed and documented as ordered by the physician.The Clinical Manager will review all wound care documentation weekly to ensure compliance and accurate documentation that reflects the plan of care.The Director will distribute and review the agency policy "Assessment/Reassessment" to include the "Procedure for Subsequent Assessments".Clinical Managers are responsible for notifying additional disciplines ordered for a patient and documenting the time and date of notification. Clinical Managers will keep a log of additional disciplines ordered and date the evaluation was completed. The Clinical Manager will ensure documentation is completed if evaluation not done within 48 hours and that the physician was notified.The Clinical Manager will monitor frequency variances weekly and ensure that a missed	01/14/2012

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	black foam as ordered by the physician. 2. Clinical record number 3 included a verbal order dated 10-21-11 that states, "Mental health nurse may eval [evaluate] pt [patient] and a verbal order dated 12-8-11 that states, "MSW [medical social worker] 1w1 Eval & Treat [1 time per week for 1 week to evaluate and treat] effective date 12-10-11. A. The record failed to evidence the patient had been evaluated by the mental health nurse or the medical social worker. B. The supervising nurse, employee F, indicated, on 12-15-11 at 12:20 PM, the patient had not yet been evaluated by the mental health nurse of the medical social worker. C. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "Nursing/Psychiatric Nursing initial assessment. Performed by a qualified Registered Nurse within 48 hours of receipt of reverral unless otherwise requested by patient/caregiver and/or the physician-ordered start of care." 3. Clinical record number 4 included a plan of care established by the physician for the certification period 11-16-11 to		visit form is completed, sent to the physician and filed in the medical record if visits are not conducted per the plan of care. The Director is responsible for on-going compliance of this regulation and will perform random audits monthly. 1. Clinical Record #1-wound care orders reviewed with RN and re-educated on implementing orders and documenting care as ordered by MD.2. Clinical Record #3 - documentation completed that MSW and mental health nurse evaluations not completed as ordered. MD notification documented. MSW visit completed 12/19/11 and Mental Health visit performed on 12/22/11 after discharge from acute care facility and new orders obtained.3.Clinical Record #4 - Missed visit records completed for 11/19/11 and 11/25/11 and physician notified.4. Clinical Record #7 - MD order dated 11/15/11 reviewed with RNand re-educated on implementing orders and documenting care as ordered by MD.	

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	01-14-12 that identifies the patient was to receive SN visits 2 times per week for 1 week, 3 times per week for 1 week, 2 times per week for 5 weeks, and then 1 time per week for 2 weeks effective 11-16-11. A. The record failed to evidence any skilled nurse visits had been provided during week 2, 11-19-11 to 11-25-11. B. The supervising nurse, employee F, stated, on 12-15-11 at 12:30 PM, 'The [skilled nurse] visits were missed." C. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "Intermittent Skilled Nursing Visit. Performed by a Registered Nurse or Licensed Practical Nurse as appropriate to the visit . . . Scheduled visit - Performed by the nurse in accordance with the orders." 4. Clinical record number 7 included a plan of care established by the physician for the certification period 11-16-11 to 01-14-12 that states, "Daily wound care to right knee . . . remove staple on 11/28/11, apply steri strips to incision line and leave open to air." A. The skilled nurse visit note dated			

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	11-28-11 failed to evidence the skilled nurse had applied the steri strips to the right knee incision after removing the staples. B. The supervising nurse, employee F, indicated, on 12-15-11 at 9:55 AM, the 11-28-11 skilled nurse visit note did not evidence the skilled nurse had applied the steri strips to the right knee incision after removing the staples.			
N0527	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. Based on clinical record and agency policy review, the agency failed to ensure the physician had been updated with significant information regarding patients' conditions in 2 (#s 2 and 11) of 12 records reviewed creating the potential to affect all of the agency's 290 current patients. The findings include: 1. A home visit was completed to patient number 2 on 12-13-11 at 1:35 PM. Observation noted the patient was unable to move self, was unable to respond to questions, and required total care. The patient was observed to be sitting in a	N0527	The agency Directors/Clinical Managers will conduct an inservice for all staff related to:Notification of the physician for any change in the patients condition.The Director will distribute and review the agency process "Physician Notification of Patient Condition Change". A sign in sheet will be provided as proof of education.The Clinical Manager/Director will ensure coordination of care between disciplines, physicians and health care providers as evidenced by documentation of case conferences at start of care and at least every 60 days or as the patients condition warrants.To ensure ongoing compliance, as	01/14/2012

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	chair in a room at the top of the stairway to the second floor of the home. A. Clinical record number 2 included a skilled nurse visit note completed by employee J, a licensed practical nurse, on 11-21-11. The note states, "When this nurse arrived pts [patient's] [adult child's spouse] was pulling in - replied [the adult child's spouse] had to go & take care of some business. Pt. was left alone during that time." The note states, "Pt status report to [employee K], RN." B. During an interview with employee J, on 12-15-11 at 8:15 AM, the employee stated, "I was concerned. That's why I told the RN." C. The record failed to evidence the RN had reported the potential danger to the patient in the event of a fire or other disaster to the physician. D. During an interview with the RN, employee K, on 12-15-11 at 8:15 AM, the employee stated, "I did report it to the Dr.'s office. It is not documented." The RN also indicated she had not informed the physician of the possible need for a medical social services referral. The RN stated, "The [adult child's spouse] would not be receptive to a social worker."		part of the Quarterly Utilization Review, 10% sample of medical records will be audited. Results will be reported at the 1st Quarter PI meeting.The Director is responsible for on-going compliance with this requirement which will be monitored with the quarterly PI medical record review process.1. Clinical Record #2 (D) - RN documented notification of MD as discussed in interview with surveyor.2. Clinical Record #11 - Patient discharged from agency 9/7/11. No further follow up.	

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	2. Clinical record number 11 included a plan of care established by the physician for the certification period 08-16-11 to 10-14-11. The record identified the patient had a pertinent diagnosis of diabetes mellitus type II. The record failed to evidence the registered nurse had informed the physician of the patient's high blood sugar readings. A. The record included a skilled nurse visit note, completed by the registered nurse, employee H, on 8-24-11, that evidenced the patient's blood sugar reading was 300. (Desirable blood sugar reading is 70 to 110). The visit note failed to evidence the nurse had notified the physician of the patient's high blood sugar reading. B. A "Progress/Communication Note" completed by employee L, a registered nurse, on 8-31-11 at 2:00 PM states, "Rec'd [received] call from HHA [home health aide] . . . while at the home of [patient number 11]. [The patient] reports had fallen or passed out & EMS was called. [The patient's] blood sugar upon arrival of EMS was greater than 500." The note identifies the nurse had the home health aide check the blood sugar again at 2:10 PM and the reading was 385. The note indicates the physician was called but was not in the office and "will be back to			

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	office in approximately 30 minutes & this note will be faxed to office for MD's review." The record failed to evidence the nurse had ensured the physician was aware of the patient's high blood sugar readings. C. A skilled nurse visit note, completed by employee H, a registered nurse, on 9-1-11 evidenced the patient's blood sugar was 573 at 9:12 AM and 423 at 12 noon. The record failed to evidence the nurse had informed the physician of the patient's high blood sugar readings. D. The record included a "Missed/Reduced Visit Communication Form" dated 9-7-11 that identified a skilled nurse visit had been missed on 9-7-11 due to "Patient has physician's appointment, then admitted to hospital." E. The record included a transfer comprehensive assessment dated 9-7-11 that identified the patient had been transferred to an inpatient facility for emergent care due to "Hypo/Hyperglycemia, diabetes out of control." F. The supervising nurse, employee F, indicated, on 12-15-11 at 1:25 PM, the			

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	record did not evidence the nurse had followed up with the physician on 8-31-11 or had notified the physician of the high blood sugar readings on 9-1-11. 3. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit) policy states, "The results of all assessments are communicated to the patient and as applicable, their caregiver, other healthcare providers, and physician."			
N0537	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: Based on clinical record and agency policy review and interview, the agency failed to ensure treatments and visits had been provided as ordered on the plan of care in 4 (#s 1, 3, 4, and 7) of 12 records reviewed. The findings include: 1. Clinical record number 1 included a physician order dated 10-19-11 that states, "Left posterior leg, wound vac @ 125 mm continuous suction with black foam. Place Promogran or equivalent into wound bed under black foam." A. A skilled nurse (SN) visit note	N0537	The agency Directors/Clinical Managers will conduct an inservice for all staff regarding:Written plan of care will be followed and documented as ordered by the physician.The Clinical Manager will review all wound care documentation weekly to ensure compliance and accurate documentation that reflects the plan of care.The Director will distribute and review the agency policy "Assessment/Reassessment" to include the "Procedure for Subsequent Assessments".Clinical Managers are responsible for notifying additional disciplines ordered for a patient and documenting the time and date of	01/14/2012

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	dated 10-28-11 failed to evidence the SN had placed the Promogran or equivalent into the wound bed under the black foam. B. The supervising nurse, employee F, indicated, on 12-15-11 at 12:15 PM, the 10-28-11 SN visit note did not evidence the SN had placed the Promogran or equivalent into the wound bed under the black foam as ordered by the physician. 2. Clinical record number 3 included a verbal order dated 10-21-11 that states, "Mental health nurse may eval [evaluate] pt [patient] and a verbal order dated 12-8-11 that states, "MSW [medical social worker] 1w1 Eval & Treat [1 time per week for 1 week to evaluate and treat] effective date 12-10-11. A. The record failed to evidence the patient had been evaluated by the mental health nurse or the medical social worker. B. The supervising nurse, employee F, indicated, on 12-15-11 at 12:20 PM, the patient had not yet been evaluated by the mental health nurse of the medical social worker. C. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "Nursing/Psychiatric Nursing initial		notification. Clinical Managers will keep a log of additional disciplines ordered and date the evaluation was completed. The Clinical Manager will ensure documentation is completed if evaluation not done within 48 hours and that the physician was notified.The Clinical Manager will monitor frequency variances weekly and ensure that a missed visit form is completed, sent to the physician and filed in the medical record if visits are not conducted per the plan of care. The Director is responsible for on-going compliance of this regulation and will perform random audits monthly. 1. Clinical Record #1-wound care orders reviewed with RN and re-educated on implementing orders and documenting care as ordered by MD.2. Clinical Record #3 - documentation completed that MSW and mental health nurse evaluations not completed as ordered. MD notification documented. MSW visit completed 12/19/11 and Mental Health visit performed on 12/22/11 after discharge from acute care facility and new orders obtained.3.Clinical Record #4 - Missed visit records completed for 11/19/11 and 11/25/11 and physician notified.4. Clinical Record #7 - MD order dated 11/15/11 reviewed with RN and re-educated on implementing orders and documenting care as ordered by MD.	

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	assessment. Performed by a qualified Registered Nurse within 48 hours of receipt of reverral unless otherwise requested by patient/caregiver and/or the physician-ordered start of care." 3. Clinical record number 4 included a plan of care established by the physician for the certification period 11-16-11 to 01-14-12 that identifies the patient was to receive SN visits 2 times per week for 1 week, 3 times per week for 1 week, 2 times per week for 5 weeks, and then 1 time per week for 2 weeks effective 11-16-11. A. The record failed to evidence any skilled nurse visits had been provided during week 2, 11-19-11 to 11-25-11. B. The supervising nurse, employee F, stated, on 12-15-11 at 12:30 PM, 'The [skilled nurse] visits were missed." C. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "Intermittent Skilled Nursing Visit. Performed by a Registered Nurse or Licensed Practical Nurse as appropriate to the visit . . . Scheduled visit - Performed by the nurse in accordance with the orders."			

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	4. Clinical record number 7 included a plan of care established by the physician for the certification period 11-16-11 to 01-14-12 that states, "Daily wound care to right knee . . . remove staple on 11/28/11, apply steri strips to incision line and leave open to air." A. The skilled nurse visit note dated 11-28-11 failed to evidence the skilled nurse had applied the steri strips to the right knee incision after removing the staples. B. The supervising nurse, employee F, indicated, on 12-15-11 at 9:55 AM, the 11-28-11 skilled nurse visit note did not evidence the skilled nurse had applied the steri strips to the right knee incision after removing the staples.			
N0546	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. Based on clinical record and agency policy review, the agency failed to ensure	N0546	The agency Directors/Clinical Managers will conduct an inservice for all staff related	01/14/2012

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	the physician had been updated with significant information regarding patients' conditions in 2 (#s 2 and 11) of 12 records reviewed creating the potential to affect all of the agency's 290 current patients. The findings include: 1. A home visit was completed to patient number 2 on 12-13-11 at 1:35 PM. Observation noted the patient was unable to move self, was unable to respond to questions, and required total care. The patient was observed to be sitting in a chair in a room at the top of the stairway to the second floor of the home. A. Clinical record number 2 included a skilled nurse visit note completed by employee J, a licensed practical nurse, on 11-21-11. The note states, "When this nurse arrived pts [patient's] [adult child's spouse] was pulling in - replied [the adult child's spouse] had to go & take care of some business. Pt. was left alone during that time." The note states, "Pt status report to [employee K], RN." B. During an interview with employee J, on 12-15-11 at 8:15 AM, the employee stated, "I was concerned. That's why I told the RN." C. The record failed to evidence the		to:Notification of the physician for any change in the patients condition.The Director will distribute and review the agency process "Physician Notification of Patient Condition Change". A sign in sheet will be provided as proof of education.The Clinical Manager/Director will ensure coordination of care between disciplines, physicians and health care providers as evidenced by documentation of case conferences at start of care and at least every 60 days or as the patients condition warrants.To ensure ongoing compliance, as part of the Quarterly Utilization Review, 10% sample of medical records will be audited. Results will be reported at the 1st Quarter PI meeting.The Director is responsible for on-going compliance with this requirement which will be monitored with the quarterly PI medical record review process.1. Clinical Record #2 (D) - RN documented notification of MD as discussed in interview with surveyor.2. Clinical Record #11 - Patient discharged from agency 9/7/11. No further follow up.	

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	RN had reported the potential danger to the patient in the event of a fire or other disaster to the physician. D. During an interview with the RN, employee K, on 12-15-11 at 8:15 AM, the employee stated, "I did report it to the Dr.'s office. It is not documented." The RN also indicated she had not informed the physician of the possible need for a medical social services referral. The RN stated, "The [adult child's spouse] would not be receptive to a social worker." 2. Clinical record number 11 included a plan of care established by the physician for the certification period 08-16-11 to 10-14-11. The record identified the patient had a pertinent diagnosis of diabetes mellitus type II. The record failed to evidence the registered nurse had informed the physician of the patient's high blood sugar readings. A. The record included a skilled nurse visit note, completed by the registered nurse, employee H, on 8-24-11, that evidenced the patient's blood sugar reading was 300. (Desirable blood sugar reading is 70 to 110). The visit note failed to evidence the nurse had notified the physician of the patient's high blood sugar reading.			

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	B. A "Progress/Communication Note" completed by employee L, a registered nurse, on 8-31-11 at 2:00 PM states, "Rec'd [received] call from HHA [home health aide] . . . while at the home of [patient number 11]. [The patient] reports had fallen or passed out & EMS was called. [The patient's] blood sugar upon arrival of EMS was greater than 500." The note identifies the nurse had the home health aide check the blood sugar again at 2:10 PM and the reading was 385. The note indicates the physician was called but was not in the office and "will be back to office in approximately 30 minutes & this note will be faxed to office for MD's review." The record failed to evidence the nurse had ensured the physician was aware of the patient's high blood sugar readings. C. A skilled nurse visit note, completed by employee H, a registered nurse, on 9-1-11 evidenced the patient's blood sugar was 573 at 9:12 AM and 423 at 12 noon. The record failed to evidence the nurse had informed the physician of the patient's high blood sugar readings. D. The record included a "Missed/Reduced Visit Communication Form" dated 9-7-11 that identified a			

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	skilled nurse visit had been missed on 9-7-11 due to "Patient has physician's appointment, then admitted to hospital." E. The record included a transfer comprehensive assessment dated 9-7-11 that identified the patient had been transferred to an inpatient facility for emergent care due to "Hypo/Hyperglycemia, diabetes out of control." F. The supervising nurse, employee F, indicated, on 12-15-11 at 1:25 PM, the record did not evidence the nurse had followed up with the physician on 8-31-11 or had notified the physician of the high blood sugar readings on 9-1-11. 3. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit) policy states, "The results of all assessments are communicated to the patient and as applicable, their caregiver, other healthcare providers, and physician."			
N0550	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.			

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	Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had prepared the written instructions for the home health aide in 1 (# 12) of 5 records reviewed of patients that received home health aide services creating the potential to affect all patients that received home health aide services. The findings include: 1. Clinical record number 12 evidenced the patient had received skilled nursing; physical, occupational, and speech therapy services; as well home health aide services, during the certification period 7-27-11 to 9-24-11. The record evidenced a start of care date of 7-27-11 with occupational and speech therapy added effective 7-30-11. The record included a "Home Health Aide Assignment" sheet signed and dated by the occupational therapist on 8-4-11. The record failed to evidence the RN had prepared the written instructions for the home health aide. 2. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when requested on 12-15-11 at 11:30 AM and at	N0550	The agency Director/Clinical Managers will conduct an inservice to all staff related to:Medicare standard 484.36-"Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for supervision of the home health aide."A sign in sheet will be utilized as proof of education.To ensure ongoing compliance, 10% of medical records will be audited quarterly as part of the Performance Improvement process. Results will be reported at the 1st quarter 2012 PI meeting.The Director is responsible for ongoing compliance and will monitor quarterly as part of the PI program.1. Clinical Record #12-patient discharged from agency 9/24/11.	01/14/2012

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N0564	1:30 PM just prior to the exit conference. Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function; Based on clinical record and agency policy review and interview, the agency failed to ensure therapists had assisted the physician in evaluating patients as ordered in 2 (#s 6 and 10) of 8 records reviewed of patients that received therapy services creating the potential to affect all patients that received therapy from the agency. The findings include: 1. The agency's undated "Summary of Therapy Documentation Requirements" policy states, "An evaluation is completed within 48 hours of receipt of the therapy referral order." 2. The agency's 8/07 "Procedure for Subsequent Assessments: (After the Admission visit)" policy states, "The Physical, occupational, or Speech Therapist and/or a Medical Social Worker will perform the evaluation visit within 48 hours of receipt of referral unless otherwise requested by the patient/caregiver and/or the physician-ordered start of care." 3. Clinical record number 6 included a	N0564	The agency Directors/Clinical Managers will conduct an inservice for all staff regarding:Timeliness of assessment and subsequent assessments.The Director will distribute and review the agency policy "Assessment/Reassessment" to include the "Procedure for Subsequent Assessments".Clinical Managers are responsible for notifying additional disciplines ordered for a patient and documenting the time and date of notification. Clinical Managers will keep a log of additional disciplines ordered and date the evaluation was completed. The Clinical Manager will ensure documentation is completed and if evaluation not done within 48 hours, that the physician was notified.The Director is responsible for on-going compliance of this rule and will perform random audits monthly. 1. Clinical Record #6 - documentation completed addressing PT and OT evaluations not completed in 48 hours and MD notification.2.Clinical Record # 10- patient was discharged from agency 10/19/11.	01/14/2012

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	plan of care established by the physician for the certification period 10-21-11 to 12-19-11 that states, "PT 1W1 [physical therapy 1 time per week for 1 week] effective 10-22-11. OT [occupational therapy] 1W1 effective 10-22-11." A. The record evidenced the PT evaluation had not been completed until 10-25-11. B. The record evidenced the OT evaluation had not been completed until 10-27-11. C. The supervising nurse, employee F, stated, on 12-15-11 at 12:35 PM, "There is no documentation why the OT and the PT did not [complete the evaluations] within 48 hours." 4. Clinical record number 10 included a plan of care established by the physician for the certification period 10-20-11 to 12-18-11 that states, "OT 1W1 effective 10-22-11, MSW [medical social worker] 1W1 effective 10-22-11." A. The record evidenced the OT evaluation had not been completed until 10-25-11. B. The supervising nurse, employee F, stated, on 12-15-11 at 1:30 PM, "The OT			

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	evaluation was not completed within 48 hours per our policy." 5. The supervising nurse, employee F, stated, on 12-14-11 at 3:15 PM, "The therapists are to make the initial visit within 48 hours unless Dr. orders specify a different date."			
N0596	Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file review and interview, the agency failed to ensure the registered nurse (RN) had completed the administration of competency evaluations in their entirety in 3 (files A, B, and C) of 3 home health aide files reviewed of aides hired since the last survey on 12-09-08 creating the potential to affect all of patients that receive home health aide services. The findings include: 1. Personnel file A evidenced the individual had been hired on 5-5-10 to provide home health aide on behalf of the	N0596	The agency Directors will conduct an inservice for the Clinical Managers related to:Competency evaluation for a Home Health AideThe Director will distribute and review the agency's Skills Competency Checklist for Home Health Aides. A sign in sheet will be utilized as evidence education has occurred.All current Home Health Aide's competency checklist will be reviewed and skill competency's completed by an RN. The Director will review for completeness.To ensure ongoing compliance with this requirement, the Director will review and approve all Home Health Aide skills competency checklist prior to any hands on care being	01/14/2012

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	agency. The file failed to evidence the RN had administered the competency evaluation in its entirety. A. The file included a form that identified skills to be demonstrated to determine the aide's competency. The form failed to evidence the RN had determined the aide was competent to perform 484.36(a)(1)(xi) normal range of motion and positioning and 484.36(a)(1)(xi)(F) toileting and elimination. B. The form evidenced the aide's competency in the performance of these skills had been determined by employee D, another home health aide. 2. Personnel file B evidenced the individual had been hired on 8-10-11 to provide home health aide services on behalf of the agency. The file failed to evidence the RN had administered the competency evaluation in its entirety. A. The file included a form that identified skills to be demonstrated to determine the aide's competency. The form failed to evidence the RN had determined the aide was competent to perform 484.36(1)(a)(ix)(A) bed bath, 484.36(1)(a)(ix)(D) nail and skin care, 484.36(1)(a)(ix)(E) oral hygiene, and 484.36(1)(a)(x) safe transfer techniques		provided to a patient.	

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	and ambulation, 484.36(1)(a)(xi) normal range of motion and positioning. B. The form evidenced the aide's competency in the performance of these skills had been determined by employee D, another home health aide. 3. Personnel file C evidenced the individual had been hired on 8-10-11 to provide home health aide services on behalf of the agency. The file failed to evidence the RN had administered the competency evaluation in its entirety. A. The file included a form that identified skills to be demonstrated to determine the aide's competency. The form failed to evidence the RN had determined the aide was competent to perform 484.36(1)(a)(iii) reading and recording of temperature, pulse, and respiration; 484.36(1)(a)(ix)(A) bed bath, (B) sponge, tub, or shower bath, (C) shampoo, sink, tub, or bed (D) nail and skin care (E) oral hygiene (F) toileting and elimination; 484.36(1)(a)(x) safe transfer techniques and ambulation; and 484.36(1)(a)(xi) normal range of motion and positioning. B. The form evidenced the aide's competency in the performance of these skills had been determined by employees			

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	A and D, other home health aides. 4. The supervising nurse, employee F, stated, on 12-15-11 at 11:15 AM, "The aides go out into the home with preceptors [other aides] and start doing tasks. After their orientation is complete then the aide is checked off by the RN and goes out independently."			
N0597	Rule 14 Sec. (1)(I)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on personnel file review and interview, the agency failed to ensure home health aides were on or had been entered on the home health aide registry in 3 (files A, B, and C) of 3 files reviewed of aide that had been hired since the last survey on 12-09-08. The findings include: 1. Personnel file A evidenced the individual had been hired on 5-5-10 to provide home health aide services on behalf of the agency. The file failed to evidence documentation the aide was on the registry or that the agency had entered the aide onto the aide registry. 2. Personnel file B evidenced the individual had been hired on 8-10-11 to provide home health aide services on	N0597	The agency Director will complete and submit the Home Health Aide registration forms to the Indiana State Department of Health for 3 home health aides not currently registered on the site.Once registration information is received, the registration number and expiration date of the home health aide registration will be entered into the employee file database and a copy placed in the personnel file.Home Health Aide registration will be tracked with other licensure by the clinical team assistant on a monthly basis.The Director will be responsible for ongoing compliance with this rule and will perform random audits quarterly to monitor.	01/14/2012

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	behalf of the agency. The file failed to evidence documentation the aide was on the registry or that the agency had entered the aide onto the aide registry. 3. Personnel file C evidenced the individual had been hired on 8-10-11 to provide home health aide services on behalf of the agency. The file failed to evidence documentation the aide was on the registry or that the agency had entered the aide onto the aide registry. 4. The supervising nurse, employee F, indicated, on 12-15-11 at 12:55 PM, the agency had not entered aides A, B, and C on the State home health aide registry.			
N0602	Rule 14 Sec. 1(m) The home health aide shall be assigned to a particular patient by a registered nurse (or therapist in therapy only cases). Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) had prepared the written instructions for the home health aide in 1 (# 12) of 5 records reviewed of patients that received home health aide services creating the potential to affect all patients that received home health aide services.	N0602	The agency Director/Clinical Managers will conduct an inservice to all staff related to:Medicare standard 484.36-"Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for supervision of the home health aide."A sign in sheet will be utilized as proof of education.To ensure ongoing	01/14/2012

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	The findings include: 1. Clinical record number 12 evidenced the patient had received skilled nursing, physical, occupational, and speech therapy services, as well home health aide services, during the certification period 7-27-11 to 9-24-11. The record evidenced a start of care date of 7-27-11 with occupational and speech therapy added effective 7-30-11. The record included a "Home Health Aide Assignment" sheet signed and dated by the occupational therapist on 8-4-11. The record failed to evidence the RN had prepared the written instructions for the home health aide. 2. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when requested on 12-15-11 at 11:30 AM and at 1:30 PM just prior to the exit conference.		compliance, 10% of medical records will be audited quarterly as part of the Performance Improvement process. Results will be reported at the 1st quarter 2012 PI meeting.The Director is responsible for ongoing compliance and will monitor quarterly as part of the PI program.1. Clinical Record #12-patient discharged from agency 9/24/11.	
N0603	Rule 14 Sec. 1(m) The home health aide may not be assigned to perform additional tasks not included in the original competency evaluation until he or she has successfully been evaluated as competent in that task. Based on personnel file and clinical	N0603	The agency Directors/Clinical	01/14/2012

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	record review and interview, the agency failed to ensure the home health aide had been evaluated for competency in the performance of a task the agency asked the aide to perform in 1 (file D) of 1 file of a home health aide hired prior to the last survey on 12-09-08 creating the potential to affect all patients that receive home health aide services from the agency. The findings include: 1. Clinical record number 11 included a "Home Health Aide Visit Note" signed and dated by employee D, a home health aide, on 8-31-11 that identified the home health aide was in the patient's home and the patient had "passed out" possibly due to an elevated blood sugar. The note states, "Called manager was told to take BS [blood sugar] again it was 349." A. The record included a "Progress/Communication Note" signed and dated by employee L, a registered nurse, on 8-31-11. The note states, "Clinical Manager spoke with [patient number 11] while HHA [home health aide] re-checked the blood sugar." B. Personnel file D failed to evidence the home health aide had received training in the use of a glucometer to check the		Managers will conduct an inservice to all staff related to:Scope of service and competency evaluation for a Home Health AideThe Director will distribute and review the agency process "Home Health Aide Services-Tasks the Aide Can and Cannot Perform" along with the Skills Competency Checklist for Home Health Aides. A sign in sheet will be utilized as evidence education has occurred.The Director will provide documentation that both the Aide and Clinical Manager involved have been re-educated and understand the tasks the Home Health Aide can and cannot perform.10% of medical record audits will be conducted quarterly as part of the PI program to ensure ongoing compliance.The Director is responsible for on-going compliance of this regulation and will monitor quarterly as part of the PI program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157571	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/15/2011
NAME OF PROVIDER OR SUPPLIER CARETENDERS		STREET ADDRESS, CITY, STATE, ZIP CODE 1724 STATE STREET NEW ALBANY, IN47150	

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	patient's blood sugar or had been evaluated for competence in the performance of the use of a glucometer. 2. The supervising nurse, employee F, stated, on 12-15-11 at 11:35 AM, "There is no training or competency evaluation for the glucometer for [employee D]."			
N0606	Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had performed supervisory visits in 1 (# 12) of 5 records reviewed of patients that had received home health aide services creating the potential to affect all patients that received home health aide services. The findings include: 1. Clinical record number 12 evidenced the patient had received skilled nursing, physical, occupational, and speech therapy services, as well home health aide services, during the certification period 7-27-11 to 9-24-11 with a discharge date of 9-24-11. The record evidenced a start	N0606	The agency Directors/Clinical Managers will conduct an inservice regarding:Medicare standard 484.36(d)(1)-If a patient receives skilled nursing care, the registered nurse must perform the supervisory visit. If the patient is not receiving skilled nursing care, but is receiving another skilled service (physical therapy, occupational therapy or speech therapy), supervision may be provided by the appropriate therapist.The Director will distribute and review the Medicare standard and the agency process "Home Health Aide Supervisory Visit Guidelines". A sign in sheet will be utilized as proof of education.An addition will be added to the weekly schedules to prompt the RN, PT, OT or ST to	01/14/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157571	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/15/2011
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	of care date of 7-27-11 with occupational and speech therapy added effective 7-30-11. A. The record evidenced one supervisory visit, completed by the occupational therapist, on 8-10-11. B. The record failed to evidence any home health aide supervisory visit had been completed by the RN. 2. The administrator, employee E, and the supervising nurse, employee F, were unable to provide any additional documentation and/or information when requested on 12-15-11 at 11:30 AM and at 1:30 PM just prior to the exit conference. 3. The agency's undated "HHA Supervisory Visit Guidelines" policy states, "Medicare requires an RN or Qualified Therapist perform and document a supervisory visit at least every 2 weeks (14 days minimally) when HHA services are ordered."		enter the date a supervisory visit is due.To ensure ongoing compliance, 10% of medical records will be audited quarterly as part of the Performance Improvement process. Results will be reported at the 1st quarter 2012 PI meeting.The Director is responsible for ongoing compliance and will monitor quarterly as part of the PI program.	