

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157587	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/26/2013
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NAME OF PROVIDER OR SUPPLIER  AMERICAN HOME HEALTH AND HOSPICE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7506 W US HIGHWAY 40 CUMBERLAND, IN 46229
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G000000	<p>This visit was a Federal Home Health complaint investigation survey.</p> <p>Complaint number: IN00141277 - Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Survey dates: December 26, 2013</p> <p>Facility number: 011171</p> <p>Medicaid #: 200851930</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 2, 2014</p>	G000000		

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

TITLE

(X6) DATE

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

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G000224	<p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record review, policy review, and interview, the home health agency failed to ensure the registered nurse responsible for the supervision of the Home Health Aide (HHA) ensured the HHA followed the aide plan of care in 1 of 3 records reviewed of patients that were receiving HHA services. (#1)</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 11/26/13, included a Home Health Certification and Plan of Care for the certification period of 11/26/13 - 1/24/14 with orders for the HHA to visit the patient two times a week for one week and three times a week for nine weeks to assist with personal care / light housekeeping as needed. The record also included a HHA care plan with orders for patient ambulation / mobility with assist preformed by the HHA for three times a week. The HHA Visit Record did not evidence patient ambulation / mobility for 12/2/13, 12/6/13, and 12/13/13 visits.</p>	G000224	The Director of Nursing will meet clinical staff during all staff meeting on 01/08/14 to discuss non-compliance with this CMS standard along with example of clinical record cited during the exit interview of this complaint survey. Director of Nursing or designee will reinforce that individualized aide care plan is written by a registered nurse or a qualified therapist along with written instructions for patient care. Aides will be in-serviced for appropriate documentation of their patient care visit record which must reflect that they follow aide care plan established by a registered nurse or a qualified therapist and they must document the reason if any task is not performed as instructed on aide care plan. It will be ensured that supervising nurse or therapist completes aide supervisory visit every 14 days for clients receiving skilled services and at least every 30 days for non-skilled aide services. The Director of Nursing or designee will audit 100% clinical records of active clients receiving aide services to ensure that	01/17/2014			

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	<p>There was no documentation the patient refused ambulation / mobility on these days.</p> <p>2. During an interview on 12/26/13 at 4:55 PM, Employee A, Director of Nursing, indicated the HHA did not document if the task was preformed or if the patient refused.</p> <p>3. The policy titled "Home Health Aide Care Plan" with a policy number HH:2-009.1 undated states, "The home health aide care plan will be individualized to the specific patient and will include at least: H. Specific procedure to be performed, including amount, frequency, and duration ... J. Instructions for completion of documentation."</p>		<p>written aide care plan was established and aide did follow the care plan as instructed and aide supervisory visit is made by a registered nurse or a qualified therapist as per CMS guidelines and agency policies. 50% of active and 25% of discharged clinical records will be reviewed quarterly for on-going monitoring of this corrective action plan and to ensure that this CMS standard is met. The Director of Nursing will be responsible for monitoring and implementation of this corrective action and will ensure that this deficiency is corrected and will not recur. The plan of correction was forwarded to Governing Board for review before submission.</p>		

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N000000	<p>This visit was a state Home Health complaint investigation survey.</p> <p>Complaint number: IN00141277 - Substantiated: State deficiencies related to the allegation are cited.</p> <p>Survey dates: December 26, 2013</p> <p>Facility number: 011171</p> <p>Medicaid #: 200851930</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>January 2, 2014</p>	N000000			

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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, policy review, and interview, the home health agency failed to ensure the registered nurse responsible for the supervision of the Home Health Aide (HHA) ensured the HHA followed the aide plan of care in 1 of 3 records reviewed of patients that were receiving HHA services. (#1)</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 11/26/13, included a Home Health Certification and Plan of Care for the certification period of 11/26/13 - 1/24/14 with orders for the HHA to visit the patient two times a week for one week and three times a week for nine weeks to assist with personal care / light housekeeping as needed. The record also included a HHA care plan with orders for patient ambulation / mobility with assist preformed by the HHA for three times a week. The HHA Visit Record did not evidence patient ambulation / mobility for</p>	N000606	The Director of Nursing will meet clinical staff during all staff meeting on 01/08/14 to discuss non-compliance with this State rule along with example of clinical record cited during the exit interview of this complaint survey. Director of Nursing or designee will reinforce that individualized aide care plan is written by a registered nurse or a qualified therapist along with written instructions for patient care. Aides will be in-serviced for appropriate documentation of their patient care visit record which must reflect that they follow aide care plan established by a registered nurse or a qualified therapist and they must document the reason if any task is not performed as instructed on aide care plan. It will be ensured that supervising nurse or therapist completes aide supervisory visit every 14 days for clients receiving skilled services and at least every 30 days for non-skilled aide services. The Director of Nursing or designee will audit 100% clinical records of active clients receiving aide	01/17/2014			

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	<p>12/2/13 and 12/6/13 visits. There was no documentation the patient refused ambulation / mobility on these days. The Registered Nurse should have made a supervisory visit on 12/12/13.</p> <p>2. During an interview on 12/26/13 at 4:55 PM, Employee A, Director of Nursing, indicated the HHA did not document if the task was preformed or if the patient refused.</p> <p>3. The policy titled "Home Health Aide Care Plan" with a policy number HH:2-009.1 undated states,"The home health aide care plan will be individualized to the specific patient and will include at least: H. Specific procedure to be performed, including amount, frequency, and duration ... J. Instructions for completion of documentation."</p>		<p>services to ensure that written aide care plan was established and aide did follow the care plan as instructed and aide supervisory visit is made by a registered nurse or a qualified therapist as per CMS guidelines and agency policies. 50% of active and 25% of discharged clinical records will be reviewed quarterly for on-going monitoring of this corrective action plan and to ensure that this State rule is met.The Director of Nursing will be responsible for monitoring and implementation of this corrective action and will ensure that this deficiency is corrected and will not recur.The plan of correction was forwarded to Governing Board for review before submission.</p>		