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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>157153 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/28/2013 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>DECATUR COUNTY MEMORIAL HOSPITAL HOME HEALTH CAI | STREET ADDRESS, CITY, STATE, ZIP CODE<br>425 MONTGOMERY RD<br>GREENSBURG, IN 47240 |
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| G000000 | <p>This visit was for a home health federal recertification survey. This was a partial extended survey.</p> <p>Survey dates: 3/25/13-3/28/13</p> <p>Facility #: 005328</p> <p>Medicaid #: 100264300</p> <p>Survey Team: Dawn Snider, RN, PHNS</p> <p>Census Service Type:</p> <p>Skilled Patients: 347<br/>Home Health Aide Only Patients: 7<br/>Personal Service Only Patients: 7<br/>Total: 361</p> <p>Sample:</p> <p>RR w HV: 5<br/>RR w/o HV: 5</p> <p>Total RR: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">April 3, 2013</p> | G000000 |  |  |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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| G000121            | <p><b>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b><br/>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation and review of policy, the agency failed to ensure all employees followed proper infection control technique for 2 of 5 (#1 and 2) home visit observations resulting in the potential to spread infectious diseases to other patients and staff.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 3/26/13 at 1:10 PM, the occupational therapist, employee E, was observed to use a pulse oximeter on patient #1. The employee placed it back into her bag without prior cleaning.</li> <li>On 3/26/13 at 11:30 AM, the physical therapist, employee D, was observed to place the bag containing the electrical stimulation on the floor of patient #2's residence without placing a barrier between the bag and the floor.</li> <li>The agency policy with an effective date 11/8/2010 titled "Infection Prevention: Cleaning of Equipment" states, "All non disposable equipment</li> </ol> | G000121       | <p>G 121. The PT and OT staff involved in the home visits where the deficiencies were cited, were re-educated on the date of the home visit- 032613, related to infection control, cleaning of equipment, and bag technique. All staff were re-educated on proper infection prevention, cleaning of equipment, and bag technique, per policy. This was accomplished at the staff meeting on 040913. Supervisory visits by the Assistant Administrator/Assistant Director, Linda Weigel, RN, will be performed on the PT and OT involved in the deficient visits to assure compliance by 042713. The Assistant Administrator/Assistant Director will perform quarterly supervisory visits or skill checks per skill-a-thon exercises or handwashing vingettes, on all skilled staff to assure compliance with infection prevention, cleaning of equipment, and bag technique to prevent the deficiency from re-occurring. Responsible party: Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, and Assistant Administrator/Assistant Director Linda Weigel, RN.</p> | 04/09/2013           |

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|                    | <p>shall be cleaned and decontaminated after contact with patient or other contamination. Only after proper disinfection will equipment be reused or placed in storage."</p> <p>4. The agency policy with an effective date 1/7/11 titled "HHC: Nursing Bag Technique" states, "When placing the bag on a surface in the home, the nurse will place the bag on a clean dry surface ( preferably on a chair or table; not on the floor). If no clean dry surface is available, the bag may be placed on a hard surface with a protective barrier."</p> |               |   |                      |

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| G000158  | <p>484.18<br/>ACCEPTANCE OF PATIENTS, POC, MED SUPER<br/>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on observation, clinical record review, policy review, and interview, the agency failed to ensure the visits and treatments were provided as ordered and in a timely manner for 4 of 8 active records reviewed (#1,#2, #6, and #8) with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #1, start of care (SOC) 3/9/13, included a plan of care (POC) for the certification period 3/9/13 to 5/7/13 with orders for a medical social services (MSS) 1 time a week times 2 weeks. The record failed to evidence the MSS had provided services to the patient.</li> <li>2. Clinical record #8, SOC 2/16/13, included a POC for the certification period 2/26/13 to 4/26/13 with orders that stated, " Refer to MSS for eval and treat." The record failed to evidence the MSS had provided services to the patient.</li> </ol> | G000158   | <p>G 158. Record #1 and #8. The MSW was re-educated on compliance with timely evaluations per policy on 032713. All staff were re-educated on the process for MSW referrals and timely evaluations as well as scheduling MSW visits appropriately in the computer system for the plan of care to be signed by the physician, at the staff meeting on 040913. On 041213, a meeting was held with the CEO Linda Simmons, RN, the VP of Clinical Services Diane McKinney, RN, the Director of Social Services Lori Hunter, MSW, and the Administrator/Director of Home Health Penny Hawkins-Jackson, RN, to address a plan that would prevent late evaluations from happening in the future. The FTE for the MSW was increased from PRN, to a 0.4 FTE. It was determined that appropriate staffing and utilization could be reached with an MSW staffing 16 hours per week on a routine basis. It was also determined that a PRN MSW would be hired as soon as possible to cover any visits that might need to occur over and above the 2 days allotted each week. The schedule for the</p> | 04/12/2013   |  |   |  |

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|  | <p>On 3/28/13 at 3:40 PM, the administrator / director phoned the MSS and was informed the services have not been provided to patients due to staffing problems.</p> <p>3. Clinical record #2, SOC 3/15/13, included a POC for the certification period 3/15/13 to 5/13/13 with orders for a physical therapy (P.T.) evaluation and treatment. The evaluation was completed on on 3/15/13 and physical therapy treatments were provided on 3/18/13, 3/20/13, and 3/26/2013 that included electrical stimulation to the patient's lower leg. The POC and clinical record failed to evidence any physician orders for the electrical stimulation treatment.</p> <p>On 3/27/13 at 3:30 PM, the administrator / director indicated the physical therapist had not contacted the physician for orders for the electrical stimulation treatments.</p> <p>4. Clinical record #6, SOC 12/12/12, included a POC for the certification period 2/10/13 to 4/10/13 for a home health aide 5 times a week for 8 weeks. The record failed to evidence the home health aide provided care on 3/19/13, 3/20/13, 3/21/13, and 3/22/13.</p> <p>On 3/28/13 at 4:05 PM, the</p> |   | <p>MSW is to work every Tuesday and Thursday or Friday to be able to see patients within 48 hours of an MSW referral per policy. The Administrator/Director of Home Health, Penny K. Hawkins-Jackson, RN, BSN, is responsible for maintaining MSW staff at this FTE level and hiring as needed for increases in patient census or acuity. Continual audits of all physician orders and admissions to home health will be conducted by the Administrator/Director to assure ongoing compliance with policy and regulation. Record #2. PT staff were immediately re-educated on calling the physician to approve the plan of care following admission, and for any changes to the plan of care. (032613) Follow-up education was included in the staff meeting on 040913. An audit of all admissions and orders for PT services will be completed for the next year to ensure the deficiency is not repeated. The Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, is responsible for the audits and compliance of the staff. Record #6. The Home Care Aide involved in this case went on vacation without assuring that her documentation was saved after entering it. She was counseled on return from vacation (041313), and re-educated was done on having her documentation completed within 24 hours of her</p> |  |  |   |  |

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|  | <p>administrator / director indicated the home health aide had failed to document the care provided.</p> <p>5. The agency policy with an effective date 1/13/2011 titled "HHC: Physician Plan of Treatment / Change Order" states, "The plan of treatment shall include but not be limited to: Orders for treatments, treatment modalities, laboratory tests."</p> |   | <p>home visit per policy. Follow-up education was completed at the staff meeting on 040913, for all staff, as the results of the survey were reviewed. A weekly audit of the HCA charting per visit schedule will be completed by the biller, Kristina Caplinger, and any deficiencies will be reported to the Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, to assure this deficiency is not repeated. These audits will be conducted indefinitely, until compliance is validated over time. Policy point #5. PT staff were immediately re-educated on calling the physician to approve the plan of care following admission, and for any changes to the plan of care.</p> <p>(032613) Follow-up education was included in the staff meeting for all clinicians on 040913. An audit of all admissions and orders for PT services will be completed for the next year to ensure the deficiency is not repeated. The Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, is responsible for the audits and compliance of the staff.</p> |                      |   |

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| G000159  | <p><b>484.18(a)</b><br/><b>PLAN OF CARE</b><br/>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on observation, interview, and review of clinical records and agency policy, the agency failed to ensure all patients had an individualized plan of care that included all of the required elements for 5 of 8 (#2, #3, #5, #6 and #7) active clinical records reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #2 included a plan of care for the certification period of 3/15/13 to 5/13/13 that failed to evidence the patient had a short leg brace, and life vest. These items were observed in the patient's home on 3/26/13 at 11:15 AM.</li> <li>2. Clinical record #3 included plans of care for the certification period of 1/16/13 to 3/16/13 and 3/17/13 to 5/15/13 that</li> </ol> | G000159   | G 159. Records #2, #3, #5, #6, and #7. Staff were re-educated on 040913 at the staff meeting, that all DME in a patient's home and all supplies not referenced in the orders in Locater 21 must be listed on the plan of care in Locater 14. All records will be audited at admission on a continuing basis to assure that all equipment currently listed in the assessment and OASIS will also be listed in Locater 14 of the 485/Plan of Care. The Administrator/Director Penny K. Hawkins-Jackson RRRN, BSN, will be responsible for the audits. Policy point #7. The policy was reviewed with all staff to assure compliance to this standard, at the staff meeting on 040913. | 04/09/2013   |  |   |  |

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|  | <p>failed to evidence the patient had a wheelchair, hospital bed, over the bed table, bedside commode, continuous pulse oximetry, oxygen as needed, BiPap machine, Hoyer lift, suction machine, and electric wheelchair. These items were observed in the patient's home on 3/26/13 at 9:40 AM.</p> <p>3. Clinical record #5 included a plan of care for the certification period of 2/14/13 to that 4/14/13 that failed to evidence the patient had a high back wheel chair and shower chair. These items were observed in the patient's home on 3/27/13 at 9:20 AM.</p> <p>4. Clinical record #6 included a plan of care for the certification period of 2/10/13 to 4/10/13 that failed to evidence the patient had a hospital bed and Hoyer lift.</p> <p>On 3/28/13 at 4:05 PM, the home health aide, employee F, indicated the patient had these items in the home.</p> <p>5. Clinical record #7 included skilled nurse notes dated 2/19/13, 3/5/13, and 3/19/13 that identified the patient had a Continuous Positive Airway Pressure (CPAP) machine. The plans of care for the certification period of 1/12/13 to 3/12/13 and 3/13/13 to 5/11/13 failed to evidence the patient had CPAP.</p> |   |   |                      |   |

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|                    | <p>The record also included plans of care for the certification periods 1/12/13 to 3/12/13 and 3/13/13 to 5/11/13 that were not signed by the physician.</p> <p>6. On 3/28/13 at 4:30 PM, the administrator / director indicated the durable medical equipment was not on the plans of care because of a concern regarding Medicare billing since another vendor supplied the durable medical equipment.</p> <p>7. The agency policy with an effective date 1/13/11 and titled "HHC: Physician Plan of Treatment / Change Order" states, "The plan of treatment shall include but not be limited to: ... Medical supplies and equipment."</p> |               |   |                      |

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| G000163  | <p><b>484.18(b)</b><br/><b>PERIODIC REVIEW OF PLAN OF CARE</b><br/>The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care was reviewed and signed by a physician for 1 of 4 (#7) active records reviewed of patients receiving services more than 60 days with the potential to affect all the agency's patients who receive services longer than 60 days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #7 included plans of care for the certification periods 1/12/13 to 3/12/13 and 3/13/13 to 5/11/13 that were not signed by the physician.</li> <li>2. On 3/28/13 at 4:05 PM, the administrator / director indicated it was</li> </ol> | G000163   | G 163. Record #7. The physician order was sent to VA every 60 days for signature and we do not bill before the orders are back and signed, per regulation and policy. The orders from VA are not getting signed timely, due to internal processes at the VA. We were assured that the VA is working toward a solution as this is a problem for many HH agencies. On 032713, a call was made to the VA representative in discharge planning. She promised that if we faxed the orders to her that date, she would see that they were signed and faxed back to us by 040313. The order is now back and signed as of 040913. The VA acknowledges this is a problem and they have a focused group re-working the process to promote compliance to the regulations. Marcie Schutte, Secretary, is responsible for | 04/09/2013   |  |   |  |

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|  | <p>difficult to get the VA (Veterans Administration) physicians to sign orders.</p> <p>3. The agency policy with an effective date 1/13/2011 titled "HHC: Physician Plan of Treatment/Change Order" states, "The plan shall be reviewed by the attending physician in consultation with the Agency's professional staff at intervals as the client's condition requires but at least every 60 days."</p> |   | <p>tracking unsigned orders. A new process was instituted to help assure orders are signed timely. A report will be run each week from Allscripts to audit any outstanding orders. The computer program holds all claims until orders are back and signed. Follow-up education was presented to all staff at the staff meeting on 040913, by the Administrator/Director Penny K. Hawkins-Jackson, RN, BSN.</p> |                      |   |

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| G000172  | <p><b>484.30(a)</b><br/><b>DUTIES OF THE REGISTERED NURSE</b><br/>The registered nurse regularly re-evaluates the patients nursing needs.<br/>Based on clinical record review and interview, the agency failed to ensure the registered nurse reevaluated the patient's needs at least every 60 days in 1 of 5 (#3) clinical records reviewed of patients receiving skilled nursing services for at least 60 days with the potential to affect all the patients of the agency receiving services longer than 60 days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record # 3, start of care 9/18/12, failed to evidence a recertification comprehensive assessment was completed during the last five days of the certification period.</li> <li>2. On 3/25/13 at 4:15 PM, the administrator / director indicated the comprehensive assessment had not been completed.</li> </ol> | G000172   | G 172. The late Recert OASIS was corrected on 032613, completed by the case manager Carol Humphrey, RN. Education for all staff was provided at the staff meeting on 040913, related to following OASIS guidelines, policy and regulation for timely submission of OASIS on 040913, by the Administrator/Director Peny K. Hawkins-Jackson, RN, BSN. The Assistant Administrator/Assistant Director Linda Weigel, RN, is responsible for reviewing all Recerts, Resumptions of care, follow-up OASIS, and Transfer OASIS documents for completeness, timeliness, and correctness on a weekly basis beginning 041213, to assure the deficiency does not re-occur. | 04/12/2013           |   |

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| G000186            | <p><b>484.32 THERAPY SERVICES</b><br/>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.)</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure orders for treatment were received and a plan of care was developed for the treatment provided by the physical therapist in 1 of 3 (#2) clinical records reviewed of patients receiving physical therapy with the potential to affect all the patients of the agency who receive physical therapy.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #2, start of care (SOC) 3/15/13, included a plan of care (POC) for the certification period 3/15/13 to 5/13/13 with orders for a physical therapy (P.T.) evaluation and treatment. The evaluation was completed on 3/15/13 and physical therapy treatments were provided on 3/18/13, 3/20/13, and 3/26/13 which included electrical stimulation on the patient's lower leg. The plan of care failed to evidence any physician orders for the treatments.</li> <li>2. The agency policy with an effective date 1/13/2011 titled " HHC: Physician</li> </ol> | G000186       | <p>G 186. Record #2. PT staff were immediately re-educated on calling the physician to approve the plan of care following admission, and for any changes to the plan of care.<br/>(032613)Follow-up education was included in the staff meeting on 040913. An audit of all admissions and orders for PT services will be completed for the next year to ensure the deficiency is not repeated. The Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, is responsible for the audits and compliance of the staff.Policy point #2. PT staff were immediately re-educated on calling the physician to approve the plan of care following admission, and for any changes to the plan of care.<br/>(032613)Follow-up education was included in the staff meeting for all clinicians on 040913. An audit of all admissions and orders for PT services will be completed for the next year to ensure the deficiency is not repeated. The Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, is responsible for the audits and compliance of the staff.</p> | 04/12/2013           |

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|                    | <p>Plan of Treatment / Change Order" states, "The plan of treatment shall include but not be limited to: Orders for treatments, treatment modalities, laboratory tests."</p> <p>3. On 3/27/13 at 3:30 PM, the administrator / director indicated the physical therapist had not contacted the physician after the initial evaluation visit for further orders.</p> |               |   |                      |

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| G000229            | <p><b>484.36(d)(2) SUPERVISION</b><br/>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse completed an on-site supervisory visit of the home health aide every 14 days in 2 of 4 (#5 and 6) active records reviewed of patients who received skilled and home health aide services longer than 14 days with the potential to affect all the patients of the agency receiving home health aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #5, start of care 2/14/13, included a plan of care for the certification period 2/14/13 to 4/14/13 with orders for skilled nurse and home health aide services. The record failed to evidence a registered nurse supervisory visit was made the weeks of 2/24/13 and 3/10/13.</li> <li>2. Clinical record # 6, start of care 12/12/12, included a plan of care for the certification period 2/10/13 to 4/10/13 with orders for skilled nurse and home</li> </ol> | G000229       | G 229. Clinical Record #5 and #6. Staff education was completed immediately on 032713 and re-education was completed on 040913 at the staff meeting for making supervisory visits per regulation and policy, per payer. A Case Management Grid Tool, explaining all parameters of supervision per payer, regulation, and policy was given to each clinician at the meeting for future reference. Policy Point # 3. The policy for supervisory visit frequency and compliance was reviewed and discussed at the staff meeting by the Administrator/Director Penny K. Hawkins-Jackson, RN, BSN. An audit of supervisory visits will be completed monthly for the next year to assure ongoing compliance. The audits will be completed by the Administrator/ Director Penny K. Hawkins-Jackson, RN, BSN, and the Assistant Administrator/Assistant Director Linda Weigel, RN. | 04/09/2013           |

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|  | <p>health aide services. The record failed to evidence a supervisory visit was made the week of 3/17/13.</p> <p>3. The policy with an effective date 1/7/2011 titled "HHC: Supervision of Home Care" states, "Medicaid ... Every 14 days, with or without the aide present; a shared supervisory visit must be made at least every 60 days with the aide present."</p> <p>4. On 3/27/13 at 3:15 PM, the administrator / director of clinical services indicated the supervisory visits had not been made every 14 days for patients #5 and #6.</p> |   |   |                      |   |

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| G000339  | <p>484.55(d)(1)<br/>UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse updated the comprehensive reassessment during the last five days of the certification period in 1 of 5 (#3) clinical records reviewed of patients receiving skilled nursing services for at least 60 days with the potential to affect all the patients of the agency receiving services longer than 60 days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record # 3, start of care 9/18/12, failed to evidence a recertification comprehensive assessment was completed during the last five days of the certification period.</li> <li>2. On 3/25/13 at 4:15 PM, the administrator / director indicated the comprehensive assessment had not been completed.</li> </ol> | G000339   | <p>G 339. The late Recert OASIS was corrected on 032613, completed by the case manager Carol Humphrey, RN. Education for all staff was provided at the staff meeting on 040913, related to following OASIS guidelines, policy and regulation for timely submission of OASIS on 040913, by the Administrator/Director Peny K. Hawkins-Jackson, RN, BSN. The Assistant Administrator/Assistant Director Linda Weigel, RN, is responsible for reviewing all Recerts, Resumptions of care, follow-up OASIS, and Transfer OASIS documents for completeness, timeliness, and correctness on a weekly basis beginning 041213, to assure the deficiency does not re-occur.</p> | 04/12/2013           |   |

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| N000000 | <p>This visit was for a state home health relicensure survey.</p> <p>Survey dates: 3/25/13-3/28/13</p> <p>Facility#: 005328</p> <p>Medicaid #: 100264300</p> <p>Survey Team: Dawn Snider, RN, PHNS</p> <p>Census Service Type:</p> <p>Skilled Patients: 347<br/>Home Health Aide Only Patients: 7<br/>Personal Service Only Patients: 7<br/>Total: 361</p> <p>Sample:</p> <p>RR w HV: 5<br/>RR w/o HV: 5</p> <p>Total RR: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN<br/><br/>April 3, 2013</p> | N000000 |  |  |
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| N000464            | <p>410 IAC 17-12-1(i)<br/>Home health agency administration/management<br/>Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with:<br/>(A) a documented:<br/>(i) history of tuberculosis;<br/>(ii) previously positive test result for tuberculosis; or<br/>(iii) completion of treatment for tuberculosis;<br/>or<br/>(B) newly positive results to the tuberculin skin test;<br/>must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must:<br/>(A) be completed annually; and<br/>(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on</p> |               |   |                      |

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|  | <p>a tuberculosis evaluation may not:<br/>(A) work in the home health agency; or<br/>(B) provide direct patient contact; unless approved by a physician to work.<br/>(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:<br/>(A) working for the home health agency; or<br/>(B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file review and interview, the agency failed to ensure all employees having direct patient contact had an annual PPD (purified protein derivative) for 8 of 10 files reviewed (A, B, C, D, E, F, H, and J) with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file A, date of hire 7/1/82 and first patient contact unknown, failed to evidence results of an annual PPD.</li> <li>2. Personnel file B, date of hire 9/22/1987 and first patient contact unknown, failed to evidence results of an annual PPD.</li> <li>3. Personnel file C, date of hire 8/5/02 and first patient contact unknown, failed to evidence results of an annual PPD.</li> </ol> | N000464   | <p>N 464. Personnel files #A, #B, #C, #D, #E, #F, #H, and #J. All staff were re-educated on compliance to regulation for Home Health related to PPD for all staff, on 032813 and again on 040913 at the staff meeting by the Administrator/Director Penny K. Hawkins-Jackson, RN, BSN. Arrangements were made to get all employees of Home Health assessed for the chest xray or 2-Step PPD with the hospital department "Work Well". Appointments were made for all staff who had not previously had a positive TB test and Chest Xray, to have the 2-step completed by 042713. All appropriate employees are now in the process of receiving their 2-Step PPD per policy and regulation. The policy was reviewed for correctness on 040313, as it had never been changed to reflect the hospital change to no annual PPD unless the employee presented with signs or symptoms of TB. The HR Director Amy Wickens, will be</p> | 04/27/2013           |   |

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|                    | <p>4. Personnel file D, date of hire 9/10/09 and first patient contact 9/21/09, failed to evidence results of an annual PPD.</p> <p>5. Personnel file E, date of hire 11/23/09 and first patient contact 8/24/09, failed to evidence results of an annual PPD.</p> <p>6. Personnel file F, date of hire 2/17/02 and first patient contact 12/07/11, failed to evidence results of an annual PPD.</p> <p>7. Personnel file H, date of hire 7/13/09 and first patient contact unknown, failed to evidence results of an annual PPD.</p> <p>8. Personnel file J, date of hire 1/2/06 and first patient contact unknown, failed to evidence results of an annual PPD.</p> <p>9. On 3/28/2013 at 1:40 PM, the human resources director and the administrator / director indicated PPD tests have not been done for a couple of years, and their understanding was annual PPD tests were no longer needed for employees due to being in a low risk area for tuberculosis.</p> |               | responsible for auditing the personnel files on 042713 to assure full compliance with the regulation. The personnel files will then be audited at least annually for continued compliance by the HR Director Amy Wickens. |                      |

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| N000470            | <p>410 IAC 17-12-1(m)<br/>Home health agency administration/management<br/>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.</p> <p>Based on observation and review of policy, the agency failed to ensure all employees followed proper infection control technique for 2 of 5 (#1 and 2) home visit observations resulting in the potential to spread infectious diseases to other patients and staff.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On 3/26/13 at 1:10 PM, the occupational therapist, employee E, was observed to use a pulse oximeter on patient #1. The employee placed it back into her bag without prior cleaning.</li> <li>2. On 3/26/13 at 11:30 AM, the physical therapist, employee D, was observed to place the bag containing the electrical stimulation on the floor of patient #2's residence without placing a barrier between the bag and the floor.</li> <li>3. The agency policy with an effective date 11/8/2010 titled "Infection Prevention: Cleaning of Equipment"</li> </ol> | N000470       | <p>N 470. The PT and OT staff involved in the home visits where the deficiencies were cited, were re-educated on the date of the home visit- 032613, for the deficiencies found related to infection control and cleaning of equipment. All staff were re-educated on proper infection prevention, cleaning of equipment, and bag technique, per policy. This was accomplished at the staff meeting on 040913. Supervisory visits by the Assistant Administrator/Assistant Director, Linda Weigel, RN, will be performed on the PT and OT involved in the deficient visits to assure compliance by 042713. The Assistant Administrator/Assistant Director will perform quarterly supervisory visits or skill checks per skill-a-thon exercises or handwashing vingettes, on all skilled staff to assure compliance with infection prevention, cleaning of equipment, and bag technique to prevent the deficiency from re-occurring. Responsible party: Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, and Assistant Administrator/Assistant</p> | 04/09/2013           |

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|  | <p>states, "All non disposable equipment shall be cleaned and decontaminated after contact with patient or other contamination. Only after proper disinfection will equipment be reused or placed in storage."</p> <p>4. The agency policy with an effective date 1/7/11 titled "HHC: Nursing Bag Technique" states, "When placing the bag on a surface in the home, the nurse will place the bag on a clean dry surface ( preferably on a chair or table; not on the floor). If no clean dry surface is available, the bag may be placed on a hard surface with a protective barrier."</p> |   | Director Linda Weigel, RN.  |                      |   |

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| N000522            | <p>410 IAC 17-13-1(a)<br/>Patient Care<br/>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:<br/>Based on observation, clinical record review, policy review, and interview, the agency failed to ensure the visits and treatments were provided as ordered and in a timely manner for 4 of 8 active records reviewed (#1,#2, #6, and #8) with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care (SOC) 3/9/13, included a plan of care (POC) for the certification period 3/9/13 to 5/7/13 with orders for a medical social services (MSS) 1 time a week times 2 weeks. The record failed to evidence the MSS had provided services to the patient.</p> <p>2. Clinical record #8, SOC 2/16/13, included a POC for the certification period 2/26/13 to 4/26/13 with orders that stated, " Refer to MSS for eval and treat." The record failed to evidence the MSS had provided services to the patient.</p> <p>On 3/28/13 at 3:40 PM, the</p> | N000522       | <p>N 522. Record #1 and #8. The MSW was re-educated on compliance with timely evaluations per policy on 032713. All staff were re-educated on the process for MSW referrals and timely evaluations as well as scheduling MSW visits appropriately in the computer system for the plan of care to be signed by the physician, at the staff meeting on 040913. On 041213, a meeting was held with the CEO Linda Simmons, RN, the VP of Clinical Services Diane McKinney, RN, the Director of Social Services Lori Hunter, MSW, and the Administrator/Director of Home Health Penny Hawkins-Jackson, RN, to address a plan that would prevent late evaluations from happening in the future. The FTE for the MSW was increased from PRN, to a 0.4 FTE. It was determined that appropriate staffing and utilization could be reached with an MSW staffing 16 hours per week on a routine basis. It was also determined that a PRN MSW would be hired as soon as possible to cover any visits that might need to occur over and above the 2 days allotted each week. The schedule for the</p> | 04/12/2013           |

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|  | <p>administrator / director phoned the MSS and was informed the services have not been provided to patients due to staffing problems.</p> <p>3. Clinical record #2, SOC 3/15/13, included a POC for the certification period 3/15/13 to 5/13/13 with orders for a physical therapy (P.T.) evaluation and treatment. The evaluation was completed on on 3/15/13 and physical therapy treatments were provided on 3/18/13, 3/20/13, and 3/26/2013 that included electrical stimulation to the patient's lower leg. The POC and clinical record failed to evidence any physician orders for the electrical stimulation treatment.</p> <p>On 3/27/13 at 3:30 PM, the administrator / director indicated the physical therapist had not contacted the physician for orders for the electrical stimulation treatments.</p> <p>4. Clinical record #6, SOC 12/12/12, included a POC for the certification period 2/10/13 to 4/10/13 for a home health aide 5 times a week for 8 weeks. The record failed to evidence the home health aide provided care on 3/19/13, 3/20/13, 3/21/13, and 3/22/13.</p> <p>On 3/28/13 at 4:05 PM, the administrator / director indicated the</p> |   | <p>MSW is to work every Tuesday and Thursday or Friday to be able to see patients within 48 hours of an MSW referral per policy. The Administrator/Director of Home Health, Penny K. Hawkins-Jackson, RN, BSN, is responsible for maintaining MSW staff at this FTE level and hiring as needed for increases in patient census or acuity. Continual audits of all physician orders and admissions to home health will be conducted by the Administrator/Director to assure ongoing compliance with policy and regulation. Record #2. PT staff were immediately re-educated on calling the physician to approve the plan of care following admission, and for any changes to the plan of care. (032613) Follow-up education was included in the staff meeting on 040913. An audit of all admissions and orders for PT services will be completed for the next year to ensure the deficiency is not repeated. The Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, is responsible for the audits and compliance of the staff. Record #6. The Home Care Aide involved in this case went on vacation without assuring that her documentation was saved after entering it. She was counseled on return from vacation (041313), and re-educated was done on having her documentation completed within 24 hours of her</p> |  |  |   |  |

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|                    | <p>home health aide had failed to document the care provided.</p> <p>5. The agency policy with an effective date 1/13/2011 titled "HHC: Physician Plan of Treatment / Change Order" states, "The plan of treatment shall include but not be limited to: Orders for treatments, treatment modalities, laboratory tests."</p> |               | <p>home visit per policy. Follow-up education was completed at the staff meeting on 040913, for all staff, as the results of the survey were reviewed. A weekly audit of the HCA charting per visit schedule will be completed by the biller, Kristina Caplinger, and any deficiencies will be reported to the Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, to assure this deficiency is not repeated. These audits will be conducted indefinitely, until compliance is validated over time. Policy point #5. PT staff were immediately re-educated on calling the physician to approve the plan of care following admission, and for any changes to the plan of care.</p> <p>(032613) Follow-up education was included in the staff meeting for all clinicians on 040913. An audit of all admissions and orders for PT services will be completed for the next year to ensure the deficiency is not repeated. The Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, is responsible for the audits and compliance of the staff.</p> |                      |

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| N000524            | <p>410 IAC 17-13-1(a)(1)<br/>Patient Care<br/>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on observation, interview, and review of clinical records and agency policy, the agency failed to ensure all patients had an individualized plan of care that included all of the required elements for 5 of 8 (#2, #3, #5, #6 and #7) active clinical records reviewed with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> | N000524       | N 524. Records #2, #3, #5, #6, and #7. Staff were re-educated on 040913 at the staff meeting, that all DME in a patinet's home and all supplies not referrenced in the orders in Locater 21 must be listed on the plan of care in Locater 14. All records will be audited at admission on a continuing basis to assure that all equipment currently listed in the assessment and OASIS will also be listed in Locater 14 of the 485/Plan of Care. The Administrator/Director Penny K. | 04/09/2013           |

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|  | <p>1. Clinical record #2 included a plan of care for the certification period of 3/15/13 to 5/13/13 that failed to evidence the patient had a short leg brace, and life vest. These items were observed in the patient's home on 3/26/13 at 11:15 AM.</p> <p>2. Clinical record #3 included plans of care for the certification period of 1/16/13 to 3/16/13 and 3/17/13 to 5/15/13 that failed to evidence the patient had a wheelchair, hospital bed, over the bed table, bedside commode, continuous pulse oximetry, oxygen as needed, BiPap machine, Hoyer lift, suction machine, and electric wheelchair. These items were observed in the patient's home on 3/26/13 at 9:40 AM.</p> <p>3. Clinical record #5 included a plan of care for the certification period of 2/14/13 to that 4/14/13 that failed to evidence the patient had a high back wheel chair and shower chair. These items were observed in the patient's home on 3/27/13 at 9:20 AM.</p> <p>4. Clinical record #6 included a plan of care for the certification period of 2/10/13 to 4/10/13 that failed to evidence the patient had a hospital bed and Hoyer lift.</p> <p>On 3/28/13 at 4:05 PM, the home</p> |   | Hawkins-Jackson RRRN, BSN, will be responsible for the audits. Policy point #7. The policy was reviewed with all staff to assure compliance to this standard, at the staff meeting on 040913. |  |  |   |  |

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|                    | <p>health aide, employee F, indicated the patient had these items in the home.</p> <p>5. Clinical record #7 included skilled nurse notes dated 2/19/13, 3/5/13, and 3/19/13 that identified the patient had a Continuous Positive Airway Pressure (CPAP) machine. The plans of care for the certification period of 1/12/13 to 3/12/13 and 3/13/13 to 5/11/13 failed to evidence the patient had CPAP.</p> <p>The record also included plans of care for the certification periods 1/12/13 to 3/12/13 and 3/13/13 to 5/11/13 that were not signed by the physician.</p> <p>6. On 3/28/13 at 4:30 PM, the administrator / director indicated the durable medical equipment was not on the plans of care because of a concern regarding Medicare billing since another vendor supplied the durable medical equipment.</p> <p>7. The agency policy with an effective date 1/13/11 and titled "HHC: Physician Plan of Treatment / Change Order" states, "The plan of treatment shall include but not be limited to: ... Medical supplies and equipment."</p> |               |   |                      |

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| N000526  | <p>410 IAC 17-13-1(a)(2)<br/>Patient Care<br/>Rule 13 Sec. 1(a)(2) The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist, and home health agency personnel as often as the severity of the patient's condition requires, but at least once every two (2) months.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care was reviewed and signed by a physician for 1 of 4 (#7) active records reviewed of patients receiving services more than 60 days with the potential to affect all the agency's patients who receive services longer than 60 days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #7 included plans of care for the certification periods 1/12/13 to 3/12/13 and 3/13/13 to 5/11/13 that were not signed by the physician.</li> <li>2. On 3/28/13 at 4:05 PM, the administrator / director indicated it was difficult to get the VA (Veterans Administration) physicians to sign orders.</li> <li>3. The agency policy with an effective date 1/13/2011 titled "HHC: Physician Plan of Treatment/Change Order" states, "The plan shall be reviewed by the</li> </ol> | N000526   | N 526. Record #7. The physician order was sent to VA every 60 days for signature and we do not bill before the orders are back and signed, per regulation and policy. The orders from VA are not getting signed timely, due to internal processes at the VA. We were assured that the VA is working toward a solution as this is a problem for many HH agencies. On 032713, a call was made to the VA representative in discharge planning. She promised that if we faxed the orders to her that date, she would see that they were signed and faxed back to us by 040313. The order is now back and signed as of 040913. The VA acknowledges this is a problem and they have a focused group re-working the process to promote compliance to the regulations. Marcie Schutte, Secretary, is responsible for tracking unsigned orders. A new process was instituted to help assure orders are signed timely. A report will be run each week from Allscripts to audit any outstanding orders. The computer program holds all claims until orders are back and | 04/09/2013   |  |   |  |

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|  | attending physician in consultation with the Agency's professional staff at intervals as the client's condition requires but at least every 60 days." |   | signed. Follow-up education was presented to all staff at the staff meeting on 040913, by the Administrator/Director Penny K. Hawkins-Jackson, RN, BSN. |                      |   |

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| N000541  | <p>410 IAC 17-14-1(a)(1)(B)<br/>Scope of Services<br/>Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:<br/>(B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse reevaluated the patient's needs at least every 60 days in 1 of 5 (#3) clinical records reviewed of patients receiving skilled nursing services for at least 60 days with the potential to affect all the patients of the agency receiving services longer than 60 days.</p> <p>Findings include:</p> <p>1. Clinical record # 3, start of care 9/18/12, failed to evidence a recertification comprehensive assessment was completed during the last five days of the certification period.</p> <p>2. On 3/25/13 at 4:15 PM, the administrator / director indicated the comprehensive assessment had not been completed.</p> | N000541   | N 541. The late Recert OASIS was corrected on 032613, completed by the case manager Carol Humphrey, RN. Education for all staff was provided at the staff meeting on 040913, related to following OASIS guidelines, policy and regulation for timely submission of OASIS on 040913, by the Administrator/Director Peny K. Hawkins-Jackson, RN, BSN. The Assistant Administrator/Assistant Director Linda Weigel, RN, is responsible for reviewing all Recerts, Resumptions of care, follow-up OASIS, and Transfer OASIS documents for completeness, timeliness, and correctness on a weekly basis beginning 041213, to assure the deficiency does not re-occur. | 04/12/2013   |  |   |  |

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| N000565            | <p>410 IAC 17-14-1(c)(4)<br/>Scope of Services<br/>Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall:<br/>(4) help develop the plan of care (revising as necessary);<br/>Based on clinical record and policy review and interview, the agency failed to ensure orders for treatment were received and a plan of care was developed for the treatment provided by the physical therapist in 1 of 3 (#2) clinical records reviewed of patients receiving physical therapy with the potential to affect all the patients of the agency who receive physical therapy.</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care (SOC) 3/15/13, included a plan of care (POC) for the certification period 3/15/13 to 5/13/13 with orders for a physical therapy (P.T.) evaluation and treatment. The evaluation was completed on 3/15/13 and physical therapy treatments were provided on 3/18/13, 3/20/13, and 3/26/13 which included electrical stimulation on the patient's lower leg. The plan of care failed to evidence any physician orders for the treatments.</p> <p>2. The agency policy with an effective date 1/13/2011 titled " HHC: Physician Plan of Treatment / Change Order" states,</p> | N000565       | <p>N 565. Record #2. PT staff were immediately re-educated on calling the physician to approve the plan of care following admission, and for any changes to the plan of care.<br/>(032613)Follow-up education was included in the staff meeting on 040913. An audit of all admissions and orders for PT services will be completed for the next year to ensure the deficiency is not repeated. The Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, is responsible for the audits and compliance of the staff.Policy point #5. PT staff were immediately re-educated on calling the physician to approve the plan of care following admission, and for any changes to the plan of care.<br/>(032613)Follow-up education was included in the staff meeting for all clinicians on 040913. An audit of all admissions and orders for PT services will be completed for the next year to ensure the deficiency is not repeated. The Administrator/Director Penny K. Hawkins-Jackson, RN, BSN, is responsible for the audits and compliance of the staff.</p> | 04/09/2013           |

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|                    | <p>"The plan of treatment shall include but not be limited to: Orders for treatments, treatment modalities, laboratory tests."</p> <p>3. On 3/27/13 at 3:30 PM, the administrator / director indicated the physical therapist had not contacted the physician after the initial evaluation visit for further orders.</p> |               |   |                      |

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| N000606  | <p>410 IAC 17-14-1(n)<br/>Scope of Services<br/>Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse completed an on-site supervisory visit of the home health aide every 14 days as required by agency policy in 2 of 4 (#5 and 6) active records reviewed of patients who received skilled and home health aide services longer than 14 days with the potential to affect all the patients of the agency receiving home health aide services.</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care 2/14/13, included a plan of care for the certification period 2/14/13 to 4/14/13 with orders for skilled nurse and home health aide services. The record failed to evidence a registered nurse supervisory visit was made the weeks of 2/24/13 and 3/10/13.</p> <p>2. Clinical record # 6, start of care 12/12/12, included a plan of care for the</p> | N000606   | N 606. Clinical Record #5 and #6. Staff education was completed immediately on 032713 and re-education was completed on 040913 at the staff meeting for making supervisory visits per regulation and policy, per payer. A Case Management Grid Tool, explaining all parameters of supervision per payer, regulation, and policy was given to each clinician at the meeting for future reference. Policy Point # 3. The policy for supervisory visit frequency and compliance was reviewed and discussed at the staff meeting by the Administrator/Director Penny K. Hawkins-Jackson, RN, BSN. An audit of supervisory visits will be completed monthly for the next year to assure ongoing compliance. The audits will be completed by the Administrator/ Director Penny K. Hawkins-Jackson, RN, BSN, and the Assistant Administrator/Assistant Director Linda Weigel, RN. | 04/09/2013   |  |   |  |

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|                    | <p>certification period 2/10/13 to 4/10/13 with orders for skilled nurse and home health aide services. The record failed to evidence a supervisory visit was made the week of 3/17/13.</p> <p>3. The policy with an effective date 1/7/2011 titled "HHC: Supervision of Home Care" states, "Medicaid ... Every 14 days, with or without the aide present; a shared supervisory visit must be made at least every 60 days with the aide present."</p> <p>4. On 3/27/13 at 3:15 PM, the administrator / director of clinical services indicated the supervisory visits had not been made every 14 days for patients #5 and #6.</p> |               |   |                      |