

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| G000000 | <p>This visit was for a home health federal recertification survey. This was a partial extended survey.</p> <p>Survey dates: December 03, 2013-December 06, 2013. The survey was partially extended on 12-06-13.</p> <p>Facility #: 3042.</p> <p>Medicaid: 200378860.</p> <p>Surveyor: Janet Brandt, RN, PHNS.</p> <p>Unduplicated Census: 65.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 16, 2013</p> | G000000 | | |

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

TITLE

(X6) DATE

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| G000123 | <p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION 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.</p> <p>Based on document review and interview, the agency failed to ensure the organizational chart included the position of alternate director of nursing for 1 of 1 organizational chart reviewed with the potential to affect all patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A review of the "ProCare Home Health Services - 1 Organizational Chart", dated 11-10-05, received from Employee A on 12-6-13 at 12:45 PM, verified by Employee A to be the most current organization chart for the agency, failed to identify where in the hierarchy the alternate nursing supervisor was. 2. Per interview with Employee A on 12-6-13 at 12:45 PM, the alternate director of nursing was not listed on the organizational chart and there was no further documentation available related to the organizational chart. | G000123 | The Administrator corrected this deficiency by updating the Agency's organization chart to include the alternate director of nursing down to the patient level on the organizational chart. The Board of Directors is responsible to ensure that this deficiency is not repeated. | 12/31/2013 | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | | | | |

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 | |
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| G000158 | <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review and staff interview, the agency failed to ensure visits were made as ordered on the plan of care for 7 of 12 records (#1, #2, #4, #7, #8, #11, #12) reviewed creating the potential for treatment omission and patient harm affecting all 65 active patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care (SOC) 6-13-13, included a plan of care for the certification period 10-11-13 to 12-11-13 with orders for skilled nurse 1 time weekly for 3 weeks and 1 visit every other week for 6 weeks. The home health aide was to visit 1 time weekly for 1 week, then 3 times weekly for 8 weeks and 1 time weekly for 1 week. The physical therapist was supposed to visit 2 times weekly for 4 weeks. There was no documentation that a skilled nurse visit had been done week 1 (10/11/13 - 10/12/13). There was documentation of only 1 physical therapy visit week 3, with no physical therapy visits week 1 or week</p> | G000158 | <p>Both the Director of Nurses (D.O.N.) and the Alternate Direct of Nurses (A.D.O.N.) will ensure that visits are made as ordered on the plan of care (P.O.C.) as evidenced by reviewing the weekly schedules and following up with the field staff to assure that the visits have been made. The D.O.N. has in-serviced field staff to notify her immediately if any visits have not been completed according to the P.O.C. so the physician can be notified immediately to modify the P.O.C.</p> <p>The D.O.N and the A.D.O.N. will ensure that this deficiency does not occur again.</p> | 01/02/2014 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 | |
|--|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>2. There was documentation of only 1 physical therapy visit week 4 (10/27/13 to 11/2/13). The home health aide (HHA) documentation for week 4 (10/27/13 to 11/2/13) identified only 1 HHA visit. There was no documentation that any visits were made Weeks 7 (11/14/13 - 11/23/13) and 8.</p> <p>2. Clinical record #2, SOC 2-7-13, included a plan of care for the certification period 10/5/13 to 12/3/13 with orders for the skilled nurse to visit 1 time weekly for 9 weeks and the home health aide to visit 3 times a week beginning 1-20-13. The record failed to evidence a skilled nurse visit was made Week 1 (10/5/13). During week 8 (11/17/13 to 11/23/13), only 2 home health aide visits were documented.</p> <p>3. Clinical record #4, SOC 10/28/13, included a plan of care for the certification period 10/28/13 to 12/26/13 with orders for the skilled nurse to visit 3 times weekly for 9 weeks and the home health aide to visit 5 times weekly for 6 weeks, then 4 times weekly for 1 week, 2 hours each day starting 11/10/13. The record evidenced only 4 HHA visits were made during week 4. The record also evidenced only 1 skilled nurse visit was made during week 5 (11-24-13 to 11-30-13).</p> | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>4. Clinical record #7, SOC 10/29/13, included a plan of care for the certification period 10/29/13 to 12/27/13 with orders for the physical therapist to visit 2 times weekly for 5 weeks. The record evidenced only 1 physical therapy visit was made during week 1.</p> <p>5. Clinical record #8, SOC 7/25/3, included a plan of care for the certification period 11/22/3 to 1/30/14 with orders for the skilled nurse to visit 1 time weekly for 3 weeks and then 1 time every other week for six weeks. The home health aide was to visit 2 times weekly for 8 weeks. The record failed to evidence a skilled nurse visit was made during the weeks 11-17-13 to 11-23-13 and 11-24-13 to 11-30-13. Only 1 home health aide visit was made those weeks.</p> <p>6. Clinical record #11, SOC 5/11/13, included a plan of care for the certification period 10/28/13 to 12/26/13 with orders for the skilled nurse to visit 1 time weekly for 9 weeks. The record failed to evidence a skilled nurse visit was made weeks 4 11/14/13 to 11/23/13 and 5 11/24/13-11/30/13.</p> <p>7. Clinical record #12, SOC 8-12-13, included a plan of care for the certification period 10/11/13 to 12/09/13</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>with orders for the skilled nurse to visit 1 time weekly for 3 weeks and 1 time every other week for 6 weeks. The record failed to evidenced a skilled nurse visit was made week 7 11/17/13-11/23/13.</p> <p>8. On 12/6/13 at 11:00 AM, Employee C indicated there was no further documentation available.</p> | | | |

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 | |
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| G000159 | <p>484.18(a) PLAN OF CARE 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 clinical record review and staff interview, the agency failed to ensure the plan of care listed all medical equipment/medical supplies used by/for the patient for 1 of 12 records reviewed (#4) with the potential to affect all patients of the agency.</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record #4, start of care 10-28-13, included a plan of care for the certification period 10-28-13 to 12-26-13 with orders for skilled nurse to visit 3 times a week to perform wound care and instruct patient how to do the wound care. The plan of care failed to evidence the specific wound care to be done. Employee C, on 12-5-13 at 11:59 AM, indicated there was no other documentation for the wound care and was not aware the specific treatment for | G000159 | The D.O.N. has in-serviced the field staff to ensure that P.O.C. and/or physician order is indicative of all medical equipment/medical supplies used by/for the patient. The A.D.O.N. will review notes weekly for compliance to ensure that the treatment of care complies with physicians orders and report findings to the D.O.N. The D.O.N. is responsible to ensure that this deficiency is corrected and that it does not occur again. | 01/02/2014 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | the wound had to be on the plan of care. | | | |

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 | |
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| G000170 | <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review and staff interview, the agency failed to ensure skilled nursing visits were made and wound care was performed in accordance with the plan of care in 6 (#1, #2, #4, #8, #11, #12) of 12 records reviewed with the potential to affect all the agency's patients who received skilled nursing services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care (SOC) 6-13-13, included a plan of care for the certification period 10-11-13 to 12-11-13 with orders for skilled nurse 1 time weekly for 3 weeks and 1 visit every other week for 6 weeks. There was no documentation a skilled nurse visit had been done week 1 (10/11/13 - 10/12/13). 2. Clinical record #2, SOC 2-7-13, included a plan of care for the certification period 10/5/13 to 12/3/13 with orders for the skilled nurse to visit 1 time weekly for 9 weeks. The record failed to evidence a skilled nurse visit was made Week 1 (10/5/13). 3. Clinical record #4, SOC 10/28/13, included a plan of care for the | G000170 | Both the Director of Nurses (D.O.N.) and the Alternate Direct of Nurses (A.D.O.N.) will ensure that visits are made as ordered on the plan of care (P.O.C.) and that services are performed in accordance with the plan of care as evidenced by reviewing the weekly schedule and following up with the field staff to assure that the visits have been made. Also, the Supervisors will verify that there is a written physician order for wound care and/or other services being performed. The D.O.N. has in-serviced field staff to notify her immediately if any visits have not been completed according to the P.O.C. so that the physician can be notified immediately to modify the P.O.C. | 01/02/2014 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>certification period 10/28/13 to 12/26/13 with orders for the skilled nurse to visit 3 times weekly for 9 weeks to perform wound care and instruct patient how to do the wound care. The plan of care failed to evidence the specific wound care to be done.</p> <p>A. The record evidenced only 1 skilled nurse visit was made during week 5 (11-24-13 to 11-30-13).</p> <p>B. Skilled nursing documentation dated 11-29-13 identified a soiled dressing was removed from the wound, normal saline was used to cleanse the wound, and Gentamycin ointment was applied.</p> <p>C. Employee C, on 12-5-13 at 11:59 AM, indicated there was no other documentation for the wound care and was not aware the specific treatment for the wound had to be on the plan of care.</p> <p>4. Clinical record #8, SOC 7/25/3, included a plan of care for the certification period 11/22/3 to 1/30/14 with orders for the skilled nurse to visit 1 time weekly for 3 weeks and then 1 time every other week for six weeks. The record failed to evidence a skilled nurse visit was made during the weeks 11-17-13 to 11-23-13 and 11-24-13 to 11-30-13.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>5. Clinical record #11, SOC 5/11/13, included a plan of care for the certification period 10/28/13 to 12/26/13 with orders for the skilled nurse to visit 1 time weekly for 9 weeks. The record failed to evidence a skilled nurse visit was made weeks 4 (11/14/13 to 11/23/13) and 5 (11/24/13-11/30/13).</p> <p>6. Clinical record #12, SOC 8-12-13, included a plan of care for the certification period 10/11/13 to 12/09/13 with orders for the skilled nurse to visit 1 time weekly for 3 weeks and 1 time every other week for 6 weeks. The record failed to evidenced a skilled nurse visit was made week 7 11/17/13-11/23/13.</p> <p>7. On 12/6/13 at 11:00 AM, Employee C indicated there was no further documentation available.</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| N000000 | <p>This visit was for a home health state licensure survey.</p> <p>Survey dates: December 3, 2013 - December 6, 2013.</p> <p>Facility #: 3042,</p> <p>Medicaid: 200378860.</p> <p>Surveyor: Janet Brandt, RN, PHNS</p> <p>Unduplicated Census: 65.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 16, 2013</p> | N000000 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 | |
|--|--|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| N000440 | <p>410 IAC 17-12-1(a) Home health agency administration/management 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.</p> <p>Based on document review and interview, the agency failed to ensure the organizational chart included the position of alternate director of nursing for 1 of 1 organizational chart reviewed with the potential to affect all patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A review of the "ProCare Home Health Services - 1 Organizational Chart", dated 11-10-05, received from Employee A on 12-6-13 at 12:45 PM, verified by Employee A to be the most current organization chart for the agency, failed to identify where in the hierarchy the alternate nursing supervisor was. 2. Per interview with Employee A on 12-6-13 at 12:45 PM, the alternate director of nursing was not listed on the organizational chart and there was no further documentation available related to the organizational chart. | N000440 | The Administrator corrected this deficiency by updating the Agency's organization chart to include the alternate director of nursing down to the patient level on the organizational chart. The Board of Directors is responsible to ensure that this deficiency is not repeated. | 12/31/2013 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | | | | |

| | | | | | | | |
|--|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 | |
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| N000522 | <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record review and staff interview, the agency failed to ensure visits were made as ordered on the plan of care for 7 of 12 records (#1, #2, #4, #7, #8, #11, #12) reviewed creating the potential for treatment omission and patient harm affecting all 65 active patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care (SOC) 6-13-13, included a plan of care for the certification period 10-11-13 to 12-11-13 with orders for skilled nurse 1 time weekly for 3 weeks and 1 visit every other week for 6 weeks. The home health aide was to visit 1 time weekly for 1 week, then 3 times weekly for 8 weeks and 1 time weekly for 1 week. The physical therapist was supposed to visit 2 times weekly for 4 weeks. There was no documentation that a skilled nurse visit had been done week 1 (10/11/13 - 10/12/13). There was documentation of only 1 physical therapy visit week 3, with</p> | N000522 | <p>Both the Director of Nurses (D.O.N.) and the Alternate Direct of Nurses (A.D.O.N.) will ensure that visits are made as ordered on the plan of care (P.O.C.) as evidenced by reviewing the weekly schedules and following up with the field staff to assure that the visits have been made. The D.O.N. has in-serviced field staff to notify her immediately if any visits have not been completed according to the P.O.C. so that the physician can be notified immediately to modify the P.O.C.</p> <p>The D.O.N and the A.D.O.N. will ensure that this deficiency does not occur again.</p> | 01/02/2014 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>no physical therapy visits week 1 or week 2. There was documentation of only 1 physical therapy visit week 4 (10/27/13 to 11/2/13). The home health aide (HHA) documentation for week 4 (10/27/13 to 11/2/13) identified only 1 HHA visit. There was no documentation that any visits were made Weeks 7 (11/14/13 - 11/23/13) and 8.</p> <p>2. Clinical record #2, SOC 2-7-13, included a plan of care for the certification period 10/5/13 to 12/3/13 with orders for the skilled nurse to visit 1 time weekly for 9 weeks and the home health aide to visit 3 times a week beginning 1-20-13. The record failed to evidence a skilled nurse visit was made Week 1 (10/5/13). During week 8 (11/17/13 to 11/23/13), only 2 home health aide visits were documented.</p> <p>3. Clinical record #4, SOC 10/28/13, included a plan of care for the certification period 10/28/13 to 12/26/13 with orders for the skilled nurse to visit 3 times weekly for 9 weeks and the home health aide to visit 5 times weekly for 6 weeks, then 4 times weekly for 1 week, 2 hours each day starting 11/10/13. The record evidenced only 4 HHA visits were made during week 4. The record also evidenced only 1 skilled nurse visit was made during week 5 (11-24-13 to</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 | |
|--|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>11-30-13).</p> <p>4. Clinical record #7, SOC 10/29/13, included a plan of care for the certification period 10/29/13 to 12/27/13 with orders for the physical therapist to visit 2 times weekly for 5 weeks. The record evidenced only 1 physical therapy visit was made during week 1.</p> <p>5. Clinical record #8, SOC 7/25/3, included a plan of care for the certification period 11/22/3 to 1/30/14 with orders for the skilled nurse to visit 1 time weekly for 3 weeks and then 1 time every other week for six weeks. The home health aide was to visit 2 times weekly for 8 weeks. The record failed to evidence a skilled nurse visit was made during the weeks 11-17-13 to 11-23-13 and 11-24-13 to 11-30-13. Only 1 home health aide visit was made those weeks.</p> <p>6. Clinical record #11, SOC 5/11/13, included a plan of care for the certification period 10/28/13 to 12/26/13 with orders for the skilled nurse to visit 1 time weekly for 9 weeks. The record failed to evidence a skilled nurse visit was made weeks 4 11/14/13 to 11/23/13 and 5 11/24/13-11/30/13.</p> <p>7. Clinical record #12, SOC 8-12-13, included a plan of care for the</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>certification period 10/11/13 to 12/09/13 with orders for the skilled nurse to visit 1 time weekly for 3 weeks and 1 time every other week for 6 weeks. The record failed to evidenced a skilled nurse visit was made week 7 11/17/13-11/23/13.</p> <p>8. On 12/6/13 at 11:00 AM, Employee C indicated there was no further documentation available.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|---------|---|---------|---|------------|
| N000524 | <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record review and staff interview, the agency failed to ensure the plan of care listed all medical equipment/medical supplies used by/for the patient for 1 of 12 records reviewed (#4) with the potential to affect all patients of the agency.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record #4, start of care 10-28-13, included a plan of care for the | N000524 | The D.O.N. has in-serviced the field staff to ensure that P.O.C. and/or physician order is indicative of all medical equipment/medical supplies used by/for the patient. The A.D.O.N. will review notes weekly for compliance to ensure that the treatment of care complies with physicians orders and report results to the D.O.N. The D.O.N. is responsible to ensure that this deficiency is corrected and that it does not occur again. | 01/02/2014 |
|---------|---|---------|---|------------|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>certification period 10-28-13 to 12-26-13 with orders for skilled nurse to visit 3 times a week to perform wound care and instruct patient how to do the wound care. The plan of care failed to evidence the specific wound care to be done.</p> <p>2. Employee C, on 12-5-13 at 11:59 AM, indicated there was no other documentation for the wound care and was not aware the specific treatment for the wound had to be on the plan of care.</p> | | | |

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/06/2013 | |
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| N000537 | <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review and staff interview, the agency failed to ensure skilled nursing visits were made and wound care was performed in accordance with the plan of care in 6 (#1, #2, #4, #8, #11, #12) of 12 records reviewed with the potential to affect all the agency's patients who received skilled nursing services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care (SOC) 6-13-13, included a plan of care for the certification period 10-11-13 to 12-11-13 with orders for skilled nurse 1 time weekly for 3 weeks and 1 visit every other week for 6 weeks. There was no documentation a skilled nurse visit had been done week 1 (10/11/13 - 10/12/13). 2. Clinical record #2, SOC 2-7-13, included a plan of care for the certification period 10/5/13 to 12/3/13 with orders for the skilled nurse to visit 1 time weekly for 9 weeks. The record failed to evidence a skilled nurse visit was made Week 1 (10/5/13). | N000537 | Both the Director of Nurses (D.O.N.) and the Alternate Direct of Nurses (A.D.O.N.) will ensure that visits are made as ordered on the plan of care (P.O.C.) and that services are performed in accordance with the plan of care as evidenced by reviewing the weekly schedule and following up with the field staff to assure that the visits have been made. Also, the Supervisors will verify that there is a written physician order for wound care and/or other services being performed. The D.O.N. has in-serviced field staff to notify her immediately if any visits have not been completed according to the P.O.C. so that the physician can be notified immediately to modified the P.O.C. | 01/02/2014 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>3. Clinical record #4, SOC 10/28/13, included a plan of care for the certification period 10/28/13 to 12/26/13 with orders for the skilled nurse to visit 3 times weekly for 9 weeks to perform wound care and instruct patient how to do the wound care. The plan of care failed to evidence the specific wound care to be done.</p> <p>A. The record evidenced only 1 skilled nurse visit was made during week 5 (11-24-13 to 11-30-13).</p> <p>B. Skilled nursing documentation dated 11-29-13 identified a soiled dressing was removed from the wound, normal saline was used to cleanse the wound, and Gentamycin ointment was applied.</p> <p>C. Employee C, on 12-5-13 at 11:59 AM, indicated there was no other documentation for the wound care and was not aware the specific treatment for the wound had to be on the plan of care.</p> <p>4. Clinical record #8, SOC 7/25/13, included a plan of care for the certification period 11/22/13 to 1/30/14 with orders for the skilled nurse to visit 1 time weekly for 3 weeks and then 1 time every other week for six weeks. The record failed to evidence a skilled nurse</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157538 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3512 169TH ST HAMMOND, IN 46323 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>visit was made during the weeks 11-17-13 to 11-23-13 and 11-24-13 to 11-30-13.</p> <p>5. Clinical record #11, SOC 5/11/13, included a plan of care for the certification period 10/28/13 to 12/26/13 with orders for the skilled nurse to visit 1 time weekly for 9 weeks. The record failed to evidence a skilled nurse visit was made weeks 4 (11/14/13 to 11/23/13) and 5 (11/24/13-11/30/13).</p> <p>6. Clinical record #12, SOC 8-12-13, included a plan of care for the certification period 10/11/13 to 12/09/13 with orders for the skilled nurse to visit 1 time weekly for 3 weeks and 1 time every other week for 6 weeks. The record failed to evidenced a skilled nurse visit was made week 7 11/17/13-11/23/13.</p> <p>7. On 12/6/13 at 11:00 AM, Employee C indicated there was no further documentation available.</p> | | | |