STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157117	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMERON HOME HEALTH CARE & HOSPICE	416 E MAUMEE ST ANGOLA, IN 46703

(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	This was a partial extended federal home health recertification survey. Survey dates: November 4-7, 2013. Partial Extended date: November 4, 2013 Facility Number: IN005308 Medicaid Number: 100263930 Surveyor: Miriam Bennett, RN, BSN, PHNS Census Service Type: Skilled: 208 Home Health Aide Only: 12 Personal Care Only: 1 Total: 221 Sample: RRw/HV: 5 RR w/o HV: 5 Total: 10 Quality Review: Joyce Elder, MSN, BSN, RN November 13, 2013	G000000		

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

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

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G000145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. Based on clinical record review, policy review, and interview, the agency failed to ensure a written 60 day summary was sent to the physician for 1 of 10 clinical records reviewed, with the potential to affect all the agency's patients. (# 5) Findings include 1. Clinical record #5, start of care date 9/1/13, failed to evidence a 60 day summary was completed and sent to the physician. A. On 11/6/13 at 1:35 PM, employee A indicated the agency usually puts the 60 day summary at the bottom of the next 485 to be signed by the physicians, but on 10/28 the nurse made a phone call to notify of the end of this certification period and to request further orders. B. The plan of care dated 10/31-12/29/13 failed to evidence a 60 day summary at the bottom. 2. The agency's policy titled "Home Health Care POC, orders, out of state orders, 911 and emergency" reviewed 10/1/10 states, "(2) ... A written	G000145	1. Education will be provided to all recertifying staff (RN, PT, OT, ST) regarding the 60 day summary requirement including the time frame and method of reporting. Nursing Team Leader to provide education.2. Recertifications including 60 day summaries will be reported at weekly case conference including the date the summary was sent to the physician. Case Conference to be faciliated by Nursing Team Leader or Director.3. Cincial Secretary will audit 100% of recertifications for 60 day summary.	11/25/2013

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	summary report for each patient shall be sent to the physician, ... at least every two (2) months-- we call this the "60 day summary." 3. The agency's policy titled "Coordination of Patient Care" revised 10/1/12 states, "4. A written report summarizing the patient's condition and services provided will be sent to the patient's physician at least every 60 days."			

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G000158	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. Based on clinical record review, policy review, observation, and interview, the agency failed to ensure treatments and visits were provided only as ordered on the plan of care for 3 of 10 records reviewed with the potential to affect all the agency's patients. (#4, 5, and 9) Findings include 1. Clinical record #4, start of care date 10/17/13, contained a plan of care dated 10/17-12/15/13 with orders for HHA 2-3 times a week times 9 weeks to assist with bathing and personal care and to provide good hygiene and skin care. The Home Health Aide Daily Note dated 10/18/13 failed to evidence any care was provided by the aide. 2. Clinical record #5, start of care (SOC) date 9/1/13, contained a physician order dated 11/4/13 to continue left foot inner heel aquacel AG 4 x 4 roll gauze and secure with coban, right foot inner heel pad with roll gauze and cover with coban. A. During home visit observation on	G000158	1a. NA will self audit 100% of daily documentation to ensure that visit date/time on notes matches visit date/time on time sheet.1b. All NA notes will be turned in weekly along with time sheets to the Nursing Team Leader. 1c. 100% audit of notes for completion and content prior to filing. Nursing Team Leader is responsible for audit. 2a. Nurses will determine the need for any supplies from the patient/caregiver when calling to schedule visit.2b. In the event that supplies are not present upon arrival for visit, the RN will call the physicians office for approval of a substitutionor2c. If no substitution is allowed, RN will obtain items and return to the patient's home to complete visit.3a. Instruction to all staff provided by Nursing Team Leader, related to orders, aside from initial order for evaluation each discipline is responsible for entering their own orders. (exception would be chaplain and volunteers)3b. Each clinician will audit 100% of her visits for physcians orders on a weekly basis. 3c. Monthly billing audits are performed on 100% of charts	11/25/2013

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	11/6/13 at 9:15 AM, the nurse, employee I, failed to use coban to secure the roll gauze as ordered and indicated there was not enough there and the agency did not call to notify nurse to take more to patient's home. B. The Case Communication Report dated 11/4/13 states, "Skilled nurse visit for 11.6.13 for wound care and dressing changes on inner left and right heel. cleanse wounds with normal saline cut aquacel AG strip to fit wound beds cover with folded 4 x 4, half of a roll of roll gauze and secure with half of roll of coban. Please take 4 x 4's and coban and small bottle of normal saline. Discard what is left in old bottle of normal saline." 1.) On 11/6/13 at 2:10 PM, employee A indicated the Case Communication Report is for the nurse and the nurse probably did not listen to the message. 2.) On 11/7/13 at 9:45 AM, employee C indicated the physician's office called back later and changed the right foot order to not include the aquacel AG. 3. Clinical record #9, SOC date 6/27/13 contained a physician order for Medical Social Worker (MSW). Three additional MSW visits were conducted on 8/13, 8/20, and 8/21/13. The record failed to		that were active in the prior month to verify amount, frequency and duration. Results to be given to Nursing Team Leader or Director3d. Computerized scheduling to be implemented by 1/1/14. Staff will be unable to document on visits without a subsequent order. The system will prompt the use to enter an order. Director will oversee implementation and education to staff.	

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	evidence physician orders for the additional visits. On 11/4/13 at 2:20 PM, employee A indicated the MSW made many visits to this patient's home, but they didn't have orders in the computer for the visits on 8/13, 8/20, and 8/21/13. 4. The agency's policy titled "Physician Orders-Verbal Orders" revised 10/1/12 states, "Drugs and treatments are administered by the Agency staff only as ordered by the physician. ... 1. Orders for patient care are obtained from the physician, either verbally or in writing."			

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G000159	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. Based on clinical record review, observation, and policy review, the agency failed to ensure the plan of care included all durable medical equipment (DME) used by patients for 1 of 5 home visit observations with the potential to affect all the agency's patients. (#3) Findings include 1. Clinical record #3, start of care 10/14/13, contained a Plan of Care (POC) dated 10/14-12/12/13. During observation on 11/5/13 at 10:45 AM, DME included an outside chair lift along the steps from the drive way to the home. The POC failed to include the chair lift. 2. The agency's policy titled "Home Health Care POC, orders, out of state orders, 911 and emergency," revised 10/1/10 states, "(1) the medical plan of care shall be developed in consultation	G000159	1. Director to provide review of regulation for listing of DME on 485 in staff educational meetings including equipment inside and outside of the home.2. When new DME is obtained, the script from the physician will be filed in the patients chart. When script cannot be obtained a supplemental order will be created as an addendum to the plan of care.3. At admission, resumption of care and recertification, DME will be reviewed in case conference and updated as necessary.4. Nursing Team Leader to be responsible as facilitator of case conference.	11/18/2013

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	with the home health agency staff and shall cover all pertinent diagnoses and include the following: ... (B) Types of services and equipment required."			

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G000176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) informed the physician the patient was taking Dilaudid which was not listed on the plan of care for 1 of 5 clinical records reviewed of patients receiving skilled nurse services with the potential to affect all the agency's patients who receive Skilled Nursing (SN) services. (#9) Findings include 1. Clinical record #9, start of care 6/27/13 contained a plan of care dated 6/27-8/25/13 with order for SN 1 time a week for 1 week, 2 times a week for 2 weeks, 1 time a week for two weeks, and 2 as needed visits for venipuncture or symptom management. On 7/1913 an order was written for SN to evaluate for pain medication teaching. The SN Visit Note dated 7/20/13 states the patient's family member gave patient Dilaudid, which is not listed on the agency's medication administration record, but the nurse instructed to give the	G000176	1. Review of medication reconciliation process via software performed by Nursing Team Leader2. Medications will be reviewed with the patient including prescription, OTC, herbs and vitamins atleast every 2 weeks and with any changes for skilled patients. Non-skilled patients will be reviewed monthly and with any changes.3. All changes will be communicated to physician via phone or written order.4. Medication reconciliation to be audited under the direction of the Nursing Team Leader. Audit to include 100% of charts for 3 months then 10% quarterly.	11/25/2013

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	drug anyway due to patient's pain level. The SN called the on-call physician to obtain an order for Zofran due to patient being nauseated. The SN Visit note failed to evidence the on-call physician was notified of the Dilaudid that was being taken by the patient. The clinical record failed to evidence the patient's primary physician was notified of the patient taking Dilaudid, and the medication profile failed to evidence Dilaudid was added and/or reviewed for drug interactions. 2. On 11/4/13 at 2:40 PM, employee A indicated there is no evidence in the record that the SN spoke with any physicians concerning the Dilaudid. 3. The agency's policy titled "Comprehensive assessment of patients" revised 10/1/10 states, "Drug Regimen Review. ... Medications are reviewed at admission, at recertification, and as needed. We should ask about OTC medications, herbs, vitamins, and treatments or therapies not ordered by the patient's physician and if reported these should be entered in the clinical record in a manner that makes it clear these were not ordered by the physician on the plan of care. ... Report medication issues to physician, as needed."			

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G000229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on clinical record review, policy review, and interview, the agency failed to ensure the Home Health Aide (HHA) supervisory visits were completed every 14 days for 1 of 4 patients receiving HHA and skilled services for longer than 14 days with the potential to affect all the agency's patients receiving HHA and skilled services for longer than 14 days. (#9) Findings include 1. Clinical record #9, start of care date 6/27/13, contained a plan of care dated 6/27-8/25/13 with orders for HHA 2-3 times a week times 9 weeks, Occupational Therapy evaluation, Physical Therapy evaluation, and Skilled Nurse (SN) 1 time a week times 1 week, 2 times a week times 2 weeks, 1 time a week times 2 weeks and 2 as needed visits for venipuncture or symptom management. The record failed to evidence a HHA supervisory visit was completed until 7/24/13. The next supervisory visit was completed 8/9/13, 16 days later. The record failed to evidence any more HHA	G000229	1. Skilled patients will received NA supervisory visits weekly in order to exceed the requirement. Case Managers are responsible for scheduling this visit.2. Non-skilled patients will continue to receive NA Supervisory visits at least monthly. These visits will be managed through the scheduling feature of the software. The system will generate alerts when visit deadline is approaching.3. Nursing team leader will be responsible for this process.	11/18/2013

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	supervisory visits were completed through 8/25/13. 2. On 11/4/13 at 3:20 PM, employee A indicated the patient wanted to discontinue SN visits on 7/12 so that was the last SN visit, and the other aide supervisory visits were probably missed due to patient canceling visits. 3. The agency's policy titled "Home Health Aide Supervision" revised 5/1/13 states, "1. Home Health Aides are closely supervised to ensure their competence in providing care. The registered nurse (RN) makes an onsite home supervisory visit to assess relationships and determine whether goals are being met. This is done with or without the aide's presence. a. Supervisory visit occurs at least every 14 days for skilled patients."			

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N000000	This was a home health state licensure survey. Survey dates: November 4-7, 2013. Facility Number: IN005308 Medicaid Number: 100263930 Surveyor: Miriam Bennett, RN, BSN, PHNS Census Service Type: Skilled: 208 Home Health Aide Only: 12 Personal Care Only: 1 Total: 221 Sample: RRw/HV: 5 RR w/o HV: 5 Total: 10 Quality Review: Joyce Elder, MSN, BSN, RN November 13, 2013	N000000		

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N000522	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: Based on clinical record review, policy review, observation, and interview, the agency failed to ensure treatments and visits were provided only as ordered on the plan of care for 3 of 10 records reviewed with the potential to affect all the agency's patients. (#4, 5, and 9) Findings include 1. Clinical record #4, start of care date 10/17/13, contained a plan of care dated 10/17-12/15/13 with orders for HHA 2-3 times a week times 9 weeks to assist with bathing and personal care and to provide good hygiene and skin care. The Home Health Aide Daily Note dated 10/18/13 failed to evidence any care was provided by the aide. 2. Clinical record #5, start of care (SOC) date 9/1/13, contained a physician order dated 11/4/13 to continue left foot inner heel aquacel AG 4 x 4 roll gauze and secure with coban, right foot inner heel pad with roll gauze and cover with coban. A. During home visit observation on	N000522	1a. NA will self audit 100% of daily documentation to ensure that visit date/time on notes matches visit date/time on time sheet.1b. All NA notes will be turned in weekly along with time sheets to the Nursing Team Leader. 1c. 100% audit of notes for completion and content prior to filing. Nursing Team Leader is responsible for audit. 2a. Nurses will determine the need for any supplies from the patient/caregiver when calling to schedule visit.2b. In the event that supplies are not present upon arrival for visit, the RN will call the physicians office for approval of a substitutionor2c. If no substitution is allowed, RN will obtain items and return to the patient's home to complete visit.3a. Instruction to all staff provided by Nursing Team Leader, related to orders, aside from initial order for evaluation each discipline is responsible for entering their own orders. (exception would be chaplain and volunteers)3b. Each clinician will audit 100% of her visits for physcians orders on a weekly basis. 3c. Monthly billing audits are performed on 100% of charts	11/18/2013

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	11/6/13 at 9:15 AM, the nurse, employee I, failed to use coban to secure the roll gauze as ordered and indicated there was not enough there and the agency did not call to notify nurse to take more to patient's home. B. The Case Communication Report dated 11/4/13 states, "Skilled nurse visit for 11.6.13 for wound care and dressing changes on inner left and right heel. cleanse wounds with normal saline cut aquacel AG strip to fit wound beds cover with folded 4 x 4, half of a roll of roll gauze and secure with half of roll of coban. Please take 4 x 4's and coban and small bottle of normal saline. Discard what is left in old bottle of normal saline." 1.) On 11/6/13 at 2:10 PM, employee A indicated the Case Communication Report is for the nurse and the nurse probably did not listen to the message. 2.) On 11/7/13 at 9:45 AM, employee C indicated the physician's office called back later and changed the right foot order to not include the aquacel AG. 3. Clinical record #9, SOC date 6/27/13 contained a physician order for Medical Social Worker (MSW). Three additional MSW visits were conducted on 8/13, 8/20, and 8/21/13. The record failed to		that were active in the prior month to verify amount, frequency and duration. Results to be given to Nursing Team Leader or Director3d. Computerized scheduling to be implemented by 1/1/14. Staff will be unable to document on visits without a subsequent order. The system will prompt the use to enter an order. Director will oversee implementation and education to staff.	

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	evidence physician orders for the additional visits. On 11/4/13 at 2:20 PM, employee A indicated the MSW made many visits to this patient's home, but they didn't have orders in the computer for the visits on 8/13, 8/20, and 8/21/13. 4. The agency's policy titled "Physician Orders-Verbal Orders" revised 10/1/12 states, "Drugs and treatments are administered by the Agency staff only as ordered by the physician. ... 1. Orders for patient care are obtained from the physician, either verbally or in writing."			

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N000524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (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. Based on clinical record review, observation, and policy review, the agency failed to ensure the plan of care included all durable medical equipment (DME) used by patients for 1 of 5 home visit observations with the potential to affect all the agency's patients. (#3) Findings include 1. Clinical record #3, start of care 10/14/13, contained a Plan of Care (POC)	N000524	1. Director to provide review of regulation for listing of DME on 485 in staff educational meetings including equipment inside and outside of the home.2. When new DME is obtained, the script from the physician will be filed in the patients chart. When script cannot be obtained a supplemental order will be created as an addendum to the plan of care.3. At admission, resumption of care and recertification, DME will be reviewed in case conference and	11/18/2013

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	dated 10/14-12/12/13. During observation on 11/5/13 at 10:45 AM, DME included an outside chair lift along the steps from the drive way to the home. The POC failed to include the chair lift. 2. The agency's policy titled "Home Health Care POC, orders, out of state orders, 911 and emergency," revised 10/1/10 states, "(1) the medical plan of care shall be developed in consultation with the home health agency staff and shall cover all pertinent diagnoses and include the following: ... (B) Types of services and equipment required."		updated as necessary.4. Nursing Team Leader to be responsible as facilitator of case conference.	

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N000529	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on clinical record review, policy review, and interview, the agency failed to ensure a written 60 day summary was sent to the physician for 1 of 10 clinical records reviewed, with the potential to affect all the agency's patients. (# 5) Findings include 1. Clinical record #5, start of care date 9/1/13, failed to evidence a 60 day summary was completed and sent to the physician. A. On 11/6/13 at 1:35 PM, employee A indicated the agency usually puts the 60 day summary at the bottom of the next 485 to be signed by the physicians, but on 10/28 the nurse made a phone call to notify of the end of this certification period and to request further orders. B. The plan of care dated 10/31-12/29/13 failed to evidence a 60 day summary at the bottom.	N000529	1. Education will be provided to all recertifying staff (RN, PT, OT, ST) regarding the 60 day summary requirement including the time frame and method of reporting. Nursing Team Leader to provide education.2. Recertifications including 60 day summaries will be reported at weekly case conference including the date the summary was sent to the physician. Case Conference to be faciliated by Nursing Team Leader or Director.3. Cincial Secretary will audit 100% of recertifications for 60 day summary.	11/25/2013

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	2. The agency's policy titled "Home Health Care POC, orders, out of state orders, 911 and emergency" reviewed 10/1/10 states, "(2) ... A written summary report for each patient shall be sent to the physician, ... at least every two (2) months-- we call this the "60 day summary." 3. The agency's policy titled "Coordination of Patient Care" revised 10/1/12 states, "4. A written report summarizing the patient's condition and services provided will be sent to the patient's physician at least every 60 days."			

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N000546	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) informed the physician the patient was taking Dilaudid which was not listed on the plan of care for 1 of 5 clinical records reviewed of patients receiving skilled nurse services with the potential to affect all the agency's patients who receive Skilled Nursing (SN) services. (#9) Findings include 1. Clinical record #9, start of care 6/27/13 contained a plan of care dated 6/27-8/25/13 with order for SN 1 time a week for 1 week, 2 times a week for 2 weeks, 1 time a week for two weeks, and 2 as needed visits for venipuncture or symptom management. On 7/1913 an order was written for SN to evaluate for pain medication teaching.	N000546	1. Review of medication reconciliation process via software performed by Nursing Team Leader2. Medications will be reviewed with the patient including prescription, OTC, herbs and vitamins atleast every 2 weeks and with any changes for skilled patients. Non-skilled patients will be reviewed monthly and with any changes.3. All changes will be communicated to physician via phone or written order.4. Medication reconciliation to be audited under the direction of the Nursing Team Leader. Audit to include 100% of charts for 3 months then 10% quarterly.	11/25/2013

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	The SN Visit Note dated 7/20/13 states the patient's family member gave patient Dilaudid, which is not listed on the agency's medication administration record, but the nurse instructed to give the drug anyway due to patient's pain level. The SN called the on-call physician to obtain an order for Zofran due to patient being nauseated. The SN Visit note failed to evidence the on-call physician was notified of the Dilaudid that was being taken by the patient. The clinical record failed to evidence the patient's primary physician was notified of the patient taking Dilaudid, and the medication profile failed to evidence Dilaudid was added and/or reviewed for drug interactions. 2. On 11/4/13 at 2:40 PM, employee A indicated there is no evidence in the record that the SN spoke with any physicians concerning the Dilaudid. 3. The agency's policy titled "Comprehensive assessment of patients" revised 10/1/10 states, "Drug Regimen Review. ... Medications are reviewed at admission, at recertification, and as needed. We should ask about OTC medications, herbs, vitamins, and treatments or therapies not ordered by the patient's physician and if reported these should be entered in the clinical record in			

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	a manner that makes it clear these were not ordered by the physician on the plan of care. ... Report medication issues to physician, as needed."			

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N000606	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on clinical record review, policy review, and interview, the agency failed to ensure the Home Health Aide (HHA) supervisory visits were completed every 14 days for 1 of 4 patients receiving HHA and skilled services for longer than 14 days with the potential to affect all the agency's patients receiving HHA and skilled services for longer than 14 days. (#9) Findings include 1. Clinical record #9, start of care date 6/27/13, contained a plan of care dated 6/27-8/25/13 with orders for HHA 2-3 times a week times 9 weeks, Occupational Therapy evaluation, Physical Therapy evaluation, and Skilled Nurse (SN) 1 time a week times 1 week, 2 times a week times 2 weeks, 1 time a week times 2 weeks and 2 as needed visits for venipuncture or symptom management. The record failed to evidence a HHA supervisory visit was completed until 7/24/13. The next supervisory visit was	N000606	1. Skilled patients will received NA supervisory visits weekly in order to exceed the requirement. Case Managers are responsible for scheduling this visit.2. Non-skilled patients will continue to receive NA Supervisory visits at least monthly. These visits will be managed through the scheduling feature of the software. The system will generate alerts when visit deadline is approaching.3. Nursing team leader will be responsible for this process.	11/18/2013

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	completed 8/9/13, 16 days later. The record failed to evidence any more HHA supervisory visits were completed through 8/25/13. 2. On 11/4/13 at 3:20 PM, employee A indicated the patient wanted to discontinue SN visits on 7/12 so that was the last SN visit, and the other aide supervisory visits were probably missed due to patient canceling visits. 3. The agency's policy titled "Home Health Aide Supervision" revised 5/1/13 states, "1. Home Health Aides are closely supervised to ensure their competence in providing care. The registered nurse (RN) makes an onsite home supervisory visit to assess relationships and determine whether goals are being met. This is done with or without the aide's presence. a. Supervisory visit occurs at least every 14 days for skilled patients."			