

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157015		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/14/2012	
NAME OF PROVIDER OR SUPPLIER  VISITING NURSE ASSOCIATION OF THE WABASH VALLEY IN				STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE TERRE HAUTE, IN 47804			
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G0000	<p>This visit was for a federal home health complaint investigation.</p> <p>Complaint: IN00119243, Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Survey Date: 12/12-14/12</p> <p>Facility #: 005253</p> <p>Medicaid Vendor #: 100272050A</p> <p>Surveyor: Marty Coons, RN PHNS</p> <p>Record review 5 Home Visit 1</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 21, 2012</p>	G0000					

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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G0143	<p><b>484.14(g)</b> <b>COORDINATION OF PATIENT SERVICES</b> All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses (RN) coordinated with the home health aide (HHA) providing services to ensure the patient's dressing was remaining dry between wound dressing changes in 1 of 1 (# 3) record reviewed of patients receiving dressing changes and HHA services with the potential to affect all patients receiving skilled wound care and HHA services for activities of daily living.</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care 7/31/12, failed to evidence any communication between employee C, the skilled nurse (SN), and the HHA concerning the bathing of the patient after a pressure ulcer treatment, causing a new dressing to get wet.</p> <p>A. SN visit documentation on 10/9/12 evidenced the right ankle with a stage 2 pressure ulcer and the left heel with an unstageable pressure ulcer with</p>	G0143	<p>G 143 To assure that all personnel, specifically the home health aide receives complete communication to provide care to home care patients, the following process has been initiated on 12/31/12 with all admissions to home care services: 1. The admitting clinician will provide the Home Health Aide Supervisor with the electronically produced Aide Care Plan. 2. Care Plan specific interventions will be shared with the Home Health Aide (HHA) by the Home Health Aide Supervisor. 3. The Home Health Aide Supervisor, or designated replacement will document in the Clinical Notes that the Care Plan communication was received from the admitting clinician, including the name of the individual. 4. The Home Health Aide Supervisor will notify the Case Manager of which home health aide is providing services for future communication updates regarding the Care Plan. Education of this process for all admitting clinicians will be completed by 01/11/13. All Admission communication will be monitored on an ongoing basis by the Quality Review team, who reports audit results to the Clinical</p>	01/11/2013	

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	<p>Eschar present, both areas received treatment and dressing changes per the plan of care orders.</p> <p>B. The patient's calendar for SN and HHA visits from 9/29/12 to 12/13/12 evidenced documentation that on 10/9/12 the SN visit time was from 10:25 AM to 12:30 PM and the HHA visit time was from 2:40 PM to 4:05 PM. The aide did assist the patient with bathing after the nurse had changed the dressing. On 11/6/12 the SN visit time was from 10:55 AM to 1:00 PM and the HHA visit time was from 1:55 PM to 3:05 PM. The aide did assist the patient with bathing after the nurse had changed the dressing.</p> <p>C. The clinical record also identified a "Team Care Plan as of 12/13/12" outlining the patient's problems and goals/expected outcomes and intervention, addressed the patient's SN wound care and the HHA personal care needs. The intervention failed to address keeping the wound clean and dry after each dressing change or performing the dressing change after assisting with bathing.</p> <p>2. On 12/14/12 at 10:30 AM, the clinical director indicated the patients family had been provided with specific written and verbal wound care instructions and at this</p>		Supervisor(s). The medical record audit tool was modified on 01-02-13 to include specific criteria to track admission communication in relation to home health aide services. It is the responsibility of the Quality Review Team member to report audit results at the home care team meetings beginning with the February 2013 meeting to allow for one month's data collection. The Clinical Supervisor(s) will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

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	<p>time provided the documented written instructions evidencing the patient had signed and dated on 10/11/12, with the patient's family member as the caregiver at home to provide dressing changes daily when the SN was not present in the home. The clinical supervisor further indicated the family caregiver would changed the dressing if it had been wet.</p> <p>3. The agency's "Documentation of Communication/Coordination of Care" policy stated, "To establish communication between a clinician and the physician, patient, caregiver, or others that may be involved in the care of the patient shall be documented in a consistent format."</p>			

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G0176	<p><b>484.30(a)</b> <b>DUTIES OF THE REGISTERED NURSE</b> 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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses (RN) coordinated with the home health aide (HHA) providing services to ensure the patient's dressing was remaining dry between wound dressing changes in 1 of 1 (# 3) record reviewed of patients receiving dressing changes and HHA services with the potential to affect all patients receiving skilled wound care and HHA services for activities of daily living.</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care 7/31/12, failed to evidence any communication between employee C, the skilled nurse (SN), and the HHA concerning the bathing of the patient after a pressure ulcer treatment, causing a new dressing to get wet.</p> <p>A. SN visit documentation on 10/9/12 evidenced the right ankle with a</p>	G0176	G 176 To correct the deficiency of the RN coordinating services with the home health aide, the following plans are in place.1. Revisions to the electronic medical record will be made and staff educated on the revisions by January 11 th , 2013. The revisions include the following: a. On the RN, PT, ST, or OT Care Plan, an intervention will be added as a check box to indicate a minimum of weekly communication with the HHA has occurred and the same intervention will be added to the HHA Care Plan to be checked at a minimum of weekly communication has occurred with the HHA's supervising RN, PT, ST, or OT. b. When a patient has a wound with a dressing and has orders for a home health aide, a wound intervention will be added as a check box to the HHA Care Plan. c. On the HHA Care Plan, the HHA uses the check box to document that the dressing(s) remain clean, dry, and intact. d. If the above mentioned check box cannot be checked, the HHA is expected to contact either the Case Manager, RN, or HHA Supervisor right	01/11/2013

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	<p>stage 2 pressure ulcer and the left heel with an unstageable pressure ulcer with Eschar present, both areas received treatment and dressing changes per the plan of care orders.</p> <p>B. The patient's calendar for SN and HHA visits from 9/29/12 to 12/13/12 evidenced documentation that on 10/9/12 the SN visit time was from 10:25 AM to 12:30 PM and the HHA visit time was from 2:40 PM to 4:05 PM. The aide did assist the patient with bathing after the nurse had changed the dressing. On 11/6/12 the SN visit time was from 10:55 AM to 1:00 PM and the HHA visit time was from 1:55 PM to 3:05 PM. The aide did assist the patient with bathing after the nurse had changed the dressing.</p> <p>C. The clinical record also identified a "Team Care Plan as of 12/13/12" outlining the patient's problems and goals/expected outcomes and intervention, addressed the patient's SN wound care and the HHA personal care needs. The intervention failed to address keeping the wound clean and dry after each dressing change or performing the dressing change after assisting with bathing.</p> <p>2. On 12/14/12 at 10:30 AM, the clinical director indicated the patients family had</p>		<p>away by text or verbally, and check the box on the Care Plan indicating that the dressing is not clean, dry, or intact. e. The Case Manager, RN, or HHA Supervisor is responsible for the oversight of the follow-up to the wound care. 2. The computer changes will be made by a member of the Quality Review Team and the Clinical Supervisors for the RNs, HHAs, and therapists will provide education to all Case Managers and HHAs. These changes will be made to the electronic medical record and education provided by Friday, January 11 th , 2013. 3. The Quality Review Department has added the Communication and Wound Dressing Criteria to the Admission Audit tool. All admission records will be audited for incorporation of the care coordination interventions. This monitoring will be on an on-going basis for the episode of care for each patient. The Quality Review Department will be responsible for communicating findings on a weekly basis with the Clinical Supervisors to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>been provided with specific written and verbal wound care instructions and at this time provided the documented written instructions evidencing the patient had signed and dated on 10/11/12, with the patient's family member as the caregiver at home to provide dressing changes daily when the SN was not present in the home. The clinical supervisor further indicated the family caregiver would changed the dressing if it had been wet.</p> <p>3. The agency's "Documentation of Communication/Coordination of Care" policy stated, "To establish communication between a clinician and the physician, patient, caregiver, or others that may be involved in the care of the patient shall be documented in a consistent format."</p>			

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N0000	<p>This visit was for a home health state complaint investigation.</p> <p>Complaint #: IN00119243, Substantiated: State deficiencies related to the allegation are cited.</p> <p>Survey Dates: 12/12-14/12</p> <p>Facility #: 005253</p> <p>Medicaid Vendor #: 100272050A</p> <p>Surveyors: Marty Coons, RN, PHNS</p> <p>Record Reviews-5 Home Visit-1</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 21, 2012</p>	N0000			

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N0484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses (RN) coordinated with the home health aide (HHA) providing services to ensure the patient's dressing was remaining dry between wound dressing changes in 1 of 1 (# 3) record reviewed of patients receiving dressing changes and HHA services with the potential to affect all patients receiving skilled wound care and HHA services for activities of daily living.</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care 7/31/12, failed to evidence any communication between employee C, the skilled nurse (SN), and the HHA concerning the bathing of the patient after a pressure ulcer treatment, causing a new dressing to get wet.</p> <p>A. SN visit documentation on</p>	N0484	N484To assure that all personnel, specifically the home health aide receives complete communication to provide care to home care patients, the following process has been initiated on 12/31/12 with all admissions to home care services: 1. The admitting clinician will provide the Home Health Aide Supervisor with the electronically produced Aide Care Plan. 2. Care Plan specific interventions will be shared with the Home Health Aide (HHA) by the Home Health Aide Supervisor. 3. The Home Health Aide Supervisor, or designated replacement will document in the Clinical Notes that the Care Plan communication was received from the admitting clinician, including name of individual. 4. The Home Health Aide Supervisor will notify the Case Manager of which home health aide is providing services for future communication updates regarding the Care Plan. Education of this process for all admitting clinicians will be completed by 01/11/13. All	01/11/2013			

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	<p>10/9/12 evidenced the right ankle with a stage 2 pressure ulcer and the left heel with an unstageable pressure ulcer with Eschar present, both areas received treatment and dressing changes per the plan of care orders.</p> <p>B. The patient's calendar for SN and HHA visits from 9/29/12 to 12/13/12 evidenced documentation that on 10/9/12 the SN visit time was from 10:25 AM to 12:30 PM and the HHA visit time was from 2:40 PM to 4:05 PM. The aide did assist the patient with bathing after the nurse had changed the dressing. On 11/6/12 the SN visit time was from 10:55 AM to 1:00 PM and the HHA visit time was from 1:55 PM to 3:05 PM. The aide did assist the patient with bathing after the nurse had changed the dressing.</p> <p>C. The clinical record also identified a "Team Care Plan as of 12/13/12" outlining the patient's problems and goals/expected outcomes and intervention, addressed the patient's SN wound care and the HHA personal care needs. The intervention failed to address keeping the wound clean and dry after each dressing change or performing the dressing change after assisting with bathing.</p> <p>2. On 12/14/12 at 10:30 AM, the clinical</p>		<p>Admission communication will be monitored on an ongoing basis by the Quality Review team, who reports audit results to the Clinical Supervisor(s). The medical record audit tool was modified on 01-02-13 to include specific criteria to track admission communication in relation to home health aide services. It is the responsibility of the Quality Review Team member to report audit results at the home care team meeting beginning with the February 2013 meeting to allow for one month's data collection. The Clinical Supervisor(s) will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses (RN) coordinated with the home health aide (HHA) providing services to ensure the patient's dressing was remaining dry between wound dressing changes in 1 of 1 (# 3) record reviewed of patients receiving dressing changes and HHA services with the potential to affect all patients receiving skilled wound care and HHA services for activities of daily living.</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care 7/31/12, failed to evidence any communication between employee C, the skilled nurse (SN), and the HHA concerning the bathing of the patient after a pressure ulcer treatment, causing a new dressing to get wet.</p> <p>A. SN visit documentation on 10/9/12 evidenced the right ankle with a</p>	N0545	<p>N 545To correct the deficiency of the RN coordinating services with the home health aide, the following plans are in place. 1. Revisions to the electronic medical record will be made and staff educated on the revisions by January 11 th , 2013. The revisions include the following: a. On the RN, PT, ST, or OT Care Plan, an intervention will be added as a check box to indicate a minimum of weekly communication with the HHA has occurred and the same intervention will be added to the HHA Care Plan to be checked at a minimum of weekly communication has occurred with the HHA's supervising RN, PT, ST, or OT. b. When a patient has a wound with a dressing and has orders for a home health aide, a wound intervention will be added as a check box to the HHA Care Plan. c. On the HHA Care Plan, the HHA uses the check box to document that the dressing(s) remain clean, dry, and intact. d. If the box cannot be checked, the HHA is expected to contact either the Case Manager, RN, or HHA</p>	01/11/2013

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	<p>stage 2 pressure ulcer and the left heel with an unstageable pressure ulcer with Eschar present, both areas received treatment and dressing changes per the plan of care orders.</p> <p>B. The patient's calendar for SN and HHA visits from 9/29/12 to 12/13/12 evidenced documentation that on 10/9/12 the SN visit time was from 10:25 AM to 12:30 PM and the HHA visit time was from 2:40 PM to 4:05 PM. The aide did assist the patient with bathing after the nurse had changed the dressing. On 11/6/12 the SN visit time was from 10:55 AM to 1:00 PM and the HHA visit time was from 1:55 PM to 3:05 PM. The aide did assist the patient with bathing after the nurse had changed the dressing.</p> <p>C. The clinical record also identified a "Team Care Plan as of 12/13/12" outlining the patient's problems and goals/expected outcomes and intervention, addressed the patient's SN wound care and the HHA personal care needs. The intervention failed to address keeping the wound clean and dry after each dressing change or performing the dressing change after assisting with bathing.</p> <p>2. On 12/14/12 at 10:30 AM, the clinical director indicated the patients family had</p>		<p>Supervisor right away by text or verbally, and check the box on the Care Plan indicating that the dressing is not clean, dry, or intact. e. The Case Manager, RN, or HHA Supervisor is responsible for the oversight of the follow-up to the wound care. 2. The computer changes will be made by a member of the Quality Review Team and the Clinical Supervisors for the RNs, HHAs, and therapists will provide education to all Case Managers and HHAs. These changes will be made to the electronic medical record and education provided by Friday, January 11 th , 2013.3. The Quality Review Department has added the Communication and Wound Dressing Criteria to the Admission Audit tool. All admission records will be audited for incorporation of the care coordination interventions. This monitoring will be on an on-going basis for the episode of care for each patient. The Quality Review Department will be responsible for communicating findings on a weekly basis with the Clinical Supervisors to ensure that this deficiency is corrected and will not recur.</p>		

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NAME OF PROVIDER OR SUPPLIER  VISITING NURSE ASSOCIATION OF THE WABASH VALLEY IN	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE TERRE HAUTE, IN 47804
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(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>been provided with specific written and verbal wound care instructions and at this time provided the documented written instructions evidencing the patient had signed and dated on 10/11/12, with the patient's family member as the caregiver at home to provide dressing changes daily when the SN was not present in the home. The clinical supervisor further indicated the family caregiver would changed the dressing if it had been wet.</p> <p>3. The agency's "Documentation of Communication/Coordination of Care" policy stated, "To establish communication between a clinician and the physician, patient, caregiver, or others that may be involved in the care of the patient shall be documented in a consistent format."</p>			