

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157645	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2015
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NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9333 N MERIDIAN STREET SUITE 104 INDIANAPOLIS, IN 46260
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G 000 Bldg. 00	<p>This visit was for a home health agency recertification survey. The survey was partial extended on 2-10, 2-11, 2-12, 2-13, 2-16, and 2-17-2015.</p> <p>Dates of survey: 2-9, 2-10, 2-11, 2-12, 2-13, 2-16, and 2-17-2015</p> <p>Facility #: 012680</p> <p>Medicaid Vendor #: 201083120A</p> <p>Surveyor: Deborah Franco, RN, PHNS</p> <p>Census: Past 12 months: 285 Skilled unduplicated admissions, past twelve months</p> <p>48 Home Health Aide only 15 Personal Service only 348 Total</p> <p>Current Active patients: 88 Skilled, 28 Home Health Aide only, 3 Personal Service only</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 24, 2014</p>	G 000	Initial comments reviewed 2/28/2015	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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G 110 Bldg. 00	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on document review, clinical record review, and interview, the agency failed to ensure patients were provided the current Indiana Advance Directives, including a description of applicable State law, in 12 of 12 records reviewed (1 - 12) with the potential to affect agency's current 19 patients.</p>	G 110	<p>The Admission Packets were updated to include the revised July 1, 2013 Advanced Directive on 2/9/2015. The nurses were given a copy of the revised directive at case conference on 2/18/2015 to give to our existing patients.</p> <p>The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected</p>	03/17/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. The admission package given to agency patients failed to include the state of Indiana Advanced Directives revised July 1, 2013. The admission packet contained a state of Indiana Advance Directive brochure from May 2004. 2. Clinical record 1, start of care (SOC) 12-19-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. 3. Clinical record 2, SOC 9-28-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. 4. Clinical record 3, SOC 12-12-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. During home visit on 2-11-15 at 11:30 A.M. the patient's home packet was observed to contain Advance Directive description of Indiana law dated 5-2004; this version failed to describe the physician's order scope of treatment advance directive option. 5. Clinical record 4, SOC 1-16-15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. During home visit on 2-11-15 		and will not recur		

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	<p>at 3:30 A.M. the patient's home packet was observed to contain Advance Directive description of Indiana law dated 5-2004; this version failed to describe the physician's order scope of treatment advance directive option.</p> <p>6. Clinical record 5, SOC 12-26-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. During home visit on 2-12-15 at 11:00 A.M. the patient's home packet was observed to contain Advance Directive description of Indiana law dated 5-2004; this version failed to describe the physician's order scope of treatment advance directive option.</p> <p>7. Clinical record 6, SOC 5-30-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p> <p>8. Clinical record 7, SOC 4-15-13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. Patient start of care was prior to the 7-2013 revision of Indiana Advance Directive law.</p> <p>9. Clinical record 8, SOC 9-15-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p>			

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	10. Clinical record 9, SOC 8-4-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.			
	11. Clinical record 10, SOC 7-2-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.			
	12. Clinical record 11, SOC 12-22-13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.			
	13. Clinical record 12, SOC 10-31-13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.			
	14. The Administrator indicated on 2-17-15 at 4:00 PM the agency failed to notify patients of their Advance Directive rights to include a description of current Indiana Advance Directives for all patients admitted after 7-1-13, and failed to update all active patients receiving agency services prior to that date regarding their Advance Directive rights as per Indiana Advance Directives brochure of July 1, 2013. The Administrator indicated the agency failed to change its admission packet when the			

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G 134 Bldg. 00	<p>Advance Directive brochure was updated.</p> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.</p> <p>Based on review of Indiana Administrative Code 410 IAC 17-14-1 (1)(1)(B), personnel record review, and interview, the agency administrator failed to ensure employees were qualified by confirming the home health aides were registered and in good standing on the state aide registry for 5 of 6 currently employed home health aide (K, L, M, N, O) personnel files reviewed creating the potential to affect all patients who were receiving home health aide services in the agency.</p> <p>Findings include:</p> <p>1. Indiana Administrative Code 410 IAC 17-14-1 (1)(1)(B) states, "The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: ... (B) be entered on and be in good standing</p>			G 134	<p>Personnel files are being audited on a daily basis until personnel files are current to ensure that all of our home health aides are qualified by confirming the home health aides are registered and in good standing on the state aide registry All new hires will be confirmed on the state aide registry prior to starting patient care. This is a part of our QAPI program initiative The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>		03/17/2015

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	<p>on the state aide registry."</p> <p>2. Personnel record K, a home health aide, date of hire 7-25-13 and first patient contact 9-24-13, failed to evidence the agency had determined the aide was in good standing and on the state registry prior to providing patient care.</p> <p>3. Personnel record L, a home health aide, date of hire 3-26-13 and first patient contact 3-27-13, failed to evidence the agency had determined the aide was in good standing and on the state registry prior to providing patient care.</p> <p>4. Personnel record M, a home health aide, date of hire 5-12-14 and first patient contact 5-14-14, failed to evidence the agency had determined the aide was in good standing and on the state registry prior to providing patient care.</p> <p>5. Personnel record N, a home health aide, date of hire 11-21-13 and first patient contact 11-23-13, failed to evidence the agency had determined the aide was in good standing and on the state registry prior to providing patient care.</p> <p>6. Personnel record O, a home health aide, date of hire 7-14-14 and first patient contact 7-19-14, failed to evidence the</p>			

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G 144 Bldg. 00	<p>agency had determined the aide was in good standing and on the state registry prior to providing patient care.</p> <p>7. The Administrator indicated on 2-17-14 at 4:00 PM the agency had completed competency testing on the above aides and thought the agency had completed the registration of these personnel. The Administrator was not able to provide further documentation demonstrating compliance prior to exit and indicated the staff did not have any specific recollection of when the application for registration may have been sent to Indiana State Department of Health. The Administrator indicated the agency has started a performance improvement plan on 1-5-14 regarding the creation and maintenance of personnel files in accordance with regulation, rules, and agency job descriptions.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case</p>			

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	<p>conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the clinical record and/or the minutes of case conferences established that effective interchange, reporting, and coordination of patient care occurred among all personnel rendering services to support the objectives in the patients' plan of care for 2 of 4 active records reviewed (2, 3) of patients receiving more than one of the agency's services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency policy "Coordination of Client Services", C-360, copyright Briggs, undated, states, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal case conferences; maintaining complete, current Care Plans; and written and verbal interaction " 2. Clinical record number 2, SOC (start of care) 9-26-14, contained a plan of care from 9-26 to 11-24-14 with orders for physical therapy and occupational 	G 144	The Director of Clinical Services in serviced professional staff, nurses and therapists how to include written communication notes into the EMR and case conference notes that establishes effective interchange, reporting and coordination of patient care among all personnel rendering services to support the objectives in the patients' plan of care. An in-service was held on 2/18/2015 and 3/4/2015. The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	03/17/2015

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	<p>therapy. The clinical record and the minutes of case conferences failed to evidence communication and / or coordination of care between the two disciplines. Agency case conferences during the certification period conducted on 10-15 and 10-29-14 failed to include documentation of the patients who were the subject of the conferences and the effective interchange, reporting, and coordination of patient care.</p> <p>3. Clinical record 3, SOC (start of care) 12-12-14, contained a plan of care from 12-12 to 2-9-15 with orders for skilled nursing, physical therapy, occupational therapy, and home health aide services. The clinical record and the minutes of case conferences failed to evidence communication and / or coordination of care between the three disciplines during the certification period. One communication note between PT and OT only dated 2-11-15 was in the clinical record. Agency case conferences during the certification period conducted on 1-21 and 2-4-15 failed to include documentation of the patients who were the subject of the conferences.</p> <p>4. On 2-17-15 at 4:00 PM, the Administrator indicated the agency policy permits the use of informal communication by telephone or email</p>			

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G 145 Bldg. 00	<p>among the disciplines, as well as clinical record and case conferences, to accomplish coordination of patient care in addition to clinical record and minutes of case conferences. Upon request, the Administrator was unable to provide any further documentation demonstrating compliance prior to exit.</p> <p>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.</p> <p>Based on clinical record review and interview, the agency failed to ensure that a written summary report was sent to the patient's attending physician at least every 60 days for 1 of 7 active (3) and 1 of 5 closed clinical records (2) with the potential to affect all of the agency's patients receiving home health services for greater than 60 days (3, 6, 7, and 8).</p> <p>Findings:</p> <p>1. Clinical record 3, start of care (SOC) 12-12-14, receiving physical therapy, occupational therapy, and home health aide services, failed to evidence a 60 day written summary report was sent to the patient's physician at the end of the</p>	G 145	The Director of Quality Improvement in serviced the professional staff of nurses and therapists on 2/18 and 3/4/2015 regarding where to access Plan of Care Summaries in the electronic medical record They were instructed to prepare a written summary report to be sent to the patient's attending physician every 60 days The Director of CQI will be responsible for auditing the chart every 60 days for compliance with plan of care summaries The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,	03/17/2015

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	<p>certification period reviewed 12-12-14 to 2-9-15.</p> <p>2. Clinical record 2, SOC 9-28-14, receiving skilled nursing, physical therapy, and occupational therapy services, failed to evidence a 60 day written summary report was sent to the patient's physician at the end of the certification period reviewed 9-26 to 11-24-14.</p> <p>3. Upon request, the Administrator and the agency's Quality Director, on 2-17-15 at 4:00 P.M., were unable to provide additional documentation to evidence compliance.</p>			

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G 158 Bldg. 00	<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 policy review, clinical record review, and interview, the agency failed to ensure visits were made as ordered on the Plan of Care (POC) in 4 of 12 clinical records reviewed (3, 5, 7, and 11) with the potential to affect all the agency's current 119 patients.</p> <p>Findings include:</p> <p>1. Agency policy "Plan of Care", copyright Briggs, undated, states, "Home care services are furnished under the supervision and direction of the client's physician ... The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every sixty (60) days."</p>	G 158	<p>The Director of Clinical Services in serviced professional staff on 2/18 and 3/4/2015 of the need to follow the visits as ordered on the Physician's Plan of Care The Director of Quality Improvement will ensure that the Clinical Record shows evidence that the physician was notified of missed visits. Orders will be sent to the physician to discontinue service earlier than anticipated, The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>	03/17/2015

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	<p>2. Clinical record 3, start of care (SOC) 12-12-14, contained a physician's plan of care for certification period 12-12-14 to 2-9-15 with orders for physical therapy (PT) "2W9" (2 times a week for 9 weeks). The record failed to evidence the PT followed the POC to include making visits 2 times a week during the weeks of 12-21-to 12-17-14 (1 visit); 12-28-14-to 1-3-15 (1 visit), and 1-11- to 1-17-15 (1 visit). The clinical record failed to evidence the physician was notified of these missed PT visits. The POC included orders for skilled nursing 2W1, 1W8 (2 times a week for one week, 1 time a week for 8 weeks). The clinical record failed to evidence visit notes for skilled nursing after 1-22-15 and failed to evidence an order from the physician to discontinue skilled nursing prior to the end of the certification period. The last nursing visit note on 1-22-15 indicated patient's nursing goals had been met.</p> <p>3. Clinical record 5 , SOC 12-26-14, contained a physician's plan of care for certification period 12-26-14 to 2-23-15 including orders for skilled nursing (SN) 2W9. The record failed to evidence the SN followed the POC to include making visits 2 times a week during the weeks of 12-28-14 to 1-3-15 (1 visit), 1-4 to 1-10-15 (1 visit), and 1-25 to 1-31-15 (1</p>			

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	<p>visit). The clinical record failed to evidence the physician was notified of these missed visits.</p> <p>4. Clinical record 7, SOC 4-15-13, contained a plan of care for the certification period 12-6-14 to 2-3-15 with orders for home health aide (HHA) services 3 times a week for 9 weeks. During the certification period, the clinical record evidenced HHA visits 2 times a week. The clinical record failed to evidence an interim order modifying the HHA visit frequency.</p> <p>5. Clinical record 11, SOC 12-22-13, contained a physician's plan of care for certification period 8-19 to 10-17-14 with orders for SN 2W8 and PT 2W4. The record failed to evidence the PT followed the POC to include making visits 2 times a week during the week of 9-28-to 10-4-13 (1 visit); and failed to evidence the SN followed the POC to include making 2 visits the week of 8-31 to 9-6-13. The record failed to evidence the physician was notified of the missed visits.</p> <p>6. On 2-17-15 at 4:00 PM, the Administrator and Director of Quality indicated the plans of care had not been followed as ordered by the patients' physicians and the agency policy had not</p>			

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NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9333 N MERIDIAN STREET SUITE 104 INDIANAPOLIS, IN 46260		
(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	
G 159 Bldg. 00	<p>been followed.</p> <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 policy review, clinical record review, and interview the agency failed to ensure all durable medical equipment in the home was on the plan of care for 4 of 6 home visits (3, 6,7, 8) whose clinical records were reviewed and 2 of 6 patients (1, 2) with clinical records review only, and failed to ensure the plan of care accurately reflected the medications the patient was taking for 1 of 6 home visits</p>	G 159	<p>The Director of Clinical Services in serviced the professional staff on 2/18 and 3/4/2015 to include all durable medical equipment in the home on the Plan of Care They will discontinue the practice of only including what needed to be ordered and that all medications the patient is on must be included on the plan of care An RN will review the med profile on patients opened by a therapist The Director of Quality</p>	03/17/2015	

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	<p>(4) whose clinical records were reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency policy, "Plan of Care", copyright Briggs, undated, states "The Plan of Care shall be completed in full to include: ... medications, treatments, and procedures ... medical equipment and supplies ... " During home visit on 2-11-15 at 11:30 AM of patient 3, start of care (SOC) 12-12-14, a rolling walker was observed in the home, which the patient said he/she uses, but was not listed on the plan of care (POC) for the certification period 12-12-14 to 2-9-15. During home visit on 2-12-15 at 11:00 AM of patient 7, SOC 4-15-13, a rolling walker, shower chair, and grab bars were observed in the home, which the patient said he/she uses, but were not listed on the POC for the certification period 12-6-14 to 2-3-15. Clinical record 1, SOC 12-19-14, contained a plan of care for the certification period 12-19-14 to 2-16-15 with orders for occupational therapy and speech language therapy. SOC comprehensive assessment dated 12-19-14 noted the patient used a cane 		Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur		

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	<p>but the plan of care failed to evidence a cane as durable medical equipment.</p> <p>5. Clinical record 2, SOC 9-26-14, contained a plan of care for the certification period 9-26 to 11-24-14 with orders for physical therapy and occupational therapy. The SOC comprehensive assessment noted the patient used a walker but the plan of care failed to evidence the walker as durable medical equipment.</p> <p>6. During home visit on 2-11-15 at 3:30 PM, patient 4 indicated he had taken Cipro since discharge from rehabilitation hospital and was still taking it for a urinary tract infection. The patient indicated he was not taking Coumadin. Clinical record 4, SOC 1-16-15, contained a plan of care for the certification period 1-16-15 to 3-16-15 including orders for physical therapy and speech language therapy. The plan of care failed to include the Cipro and included Coumadin. There were no interim orders to update the medications in the clinical record.</p> <p>7. During home visit for patient 6 on 2-12-15 at 2:30 P.M., a rolling walker and shower chair were observed in the home. The clinical record, SOC 5-30-14, contained a plan of care for certification</p>			

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G 170 Bldg. 00	<p>period 1-25 to 3-25-15 which failed to evidence the rolling walker and shower chair as durable medical equipment.</p> <p>8. During home visit of patient 8 on 2-16-15 at 2:00 P.M., SOC 1-13-15, a rolling walker, shower chair, cane, and wheelchair were observed in the home, which the patient said he/she uses (except the wheelchair) the equipment, but they were not listed on the POC for the certification period 1-13 to 3-13-15.</p> <p>9. The Alternate Administrator indicated on 2-17-15 at 4:00 PM, the agency policy had not been followed for the above clinical records.</p> <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 interview, the skilled nurse failed to ensure skilled nursing services were furnished as ordered on the plan of care (POC) for 1 of 4 active patients (3) receiving skilled nursing care.</p> <p>Findings include:</p>	G 170	The Director of Clinical Services in serviced the nurses on 2/18 and 3/4/2015 to send discharge orders to the patient's attending physician whenever services are discontinued earlier than ordered The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur	03/17/2015

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G 187 Bldg. 00	<p>1. Clinical record 3, SOC (start of care) 12-12-14, contained a POC from 12-12 to 2-9-15 with orders for skilled nursing 2W1, 1W8 [2 times a week for one week and 1 time a week for 8 weeks]. The clinical record failed to evidence visit notes for skilled nursing after 1-22-15 and failed to evidence an order from the physician to discontinue skilled nursing prior to the end of the certification period. The last nursing visit note on 1-22-15 indicated patients nursing goals had been met.</p> <p>2. On 2-17-15 at 4:00 P.M. the Nursing Supervisor indicated patient 3's physician should have been contacted for an order to discontinue skilled nursing services earlier than the order on the plan of care.</p> <p>484.32 THERAPY SERVICES The qualified therapist prepares clinical and progress notes.</p> <p>Based on clinical record review and interview, the agency failed to ensure the therapist submitted visit notes timely</p>	G 187	The Director of Clinical Services notified our two therapy contractors that therapy must have their notes turned into the agency within 14 days, Medical	03/17/2015

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	<p>after completing a visit for 1 of 4 records reviewed of patients receiving therapy services (1) creating the potential to affect all patients receiving therapy services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 1, SOC 12-19-14, included a plan of care established by the physician for the certification period 12-19-14 to 2-16-15 with orders for speech language therapy and occupational therapy. The clinical record failed to evidence visit notes after 12-30-14 for speech language therapy visits. 2. The Administrator and Director of Quality were unable to provide further documentation demonstrating compliance on 2-17-15 at 4:00 P.M. 		<p>Records will be responsible for ensuring that notes are scanned into the chart within 14 days The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>	

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G 188 Bldg. 00	<p>484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the therapists advised and consulted with other agency personnel regarding patients' progress toward goals and outcomes for 2 of 7 records reviewed (2, 3) of patients receiving therapy services.</p> <p>Findings include:</p> <p>1. Agency policy "Coordination of Client Services", C-360, copyright Briggs, undated, states, "All personnel furnishing services shall maintain a liaison to assure that their efforts coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through</p>	G 188	<p>The Director of Clinical Services in serviced the therapists on 2/18 and 3/42015 of the need to document consultation with other agency personnel regarding patient's progress toward goals and outcomes, All personnel furnishing services shall maintain a liaison to assure that their effort coordinated effectively and support the objectives outlined in the Plan of Care All communication between the therapist will be documented on a communication note in the case conference notes, The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>	03/17/2015

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	<p>formal case conferences; maintaining complete, current Care Plans; and written and verbal interaction "</p> <p>2. Clinical record 2, SOC (start of care) 9-26-14, contained a plan of care from 9-26 to 11-24-14 with orders for physical therapy and occupational therapy. The clinical record failed to evidence communication and / or coordination of care between the two therapists regarding the patient ' s progress toward goals and outcomes. Agency case conference meeting minutes during the certification period conducted on 10-15 and 10-29-14 failed to include the names of the patients who were the subject of the conferences and failed to evidence the attendance of any occupational therapist at the case conference meetings.</p> <p>3. Clinical record 3, SOC 12-12-14, contained a plan of care from 12-12 to 2-9-15 with orders for skilled nursing, physical therapy, occupational therapy, and home health aide services. The clinical record failed to evidence communication and / or coordination of care between the two therapists regarding the patient ' s progress toward goals and outcomes. Agency case conference meeting minutes during the certification period conducted on 1-21-15 and 2-4-15 failed to include the names of the patients</p>			

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G 215 Bldg. 00	<p>who were the subject of the conferences and failed to evidence the attendance of any occupational therapist at the case conference meetings.</p> <p>4. On 2-17-15 at 4:00 P. M., the Administrator indicated the agency policy permits the use of informal communication by telephone or email among the disciplines, as well as clinical record and case conferences, to accomplish coordination of patient care in addition to clinical record and minutes of case conferences. These informal communications are not retained as part of the clinical record or the case conference meeting minutes. Upon request, the Administrator was unable to provide any further documentation demonstrating the therapists advised and consulted with other agency personnel regarding patients 2 and 3 during the certification periods reviewed.</p> <p>484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient.</p>	G 215	An audit tool has been added to the front of our personnel files	03/17/2015

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	<p>Based on review of job description, personnel file review, and interview, the agency failed to ensure home health aides (HHA) received 12 hours of continuing education, or prorated equivalent, for 1 of 8 HHA personnel files reviewed (N).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency job description, copyright Briggs, undated, for HHA states, "Attends in-service programs to meet compliance requirements." 2. Personnel files for HHA Employee N, date of hire 11/21/13, failed to evidence 12 hours of continuing education, or prorated equivalent for 2014. The employee personnel file failed to evidence any documentation of continuing education in 2014. 3. On 2-17-15 at 4:00 PM, upon request, the Alternate Director of Nursing, who supervised the HHAs, was unable to provide further documentation demonstrating compliance. 		<p>which includes the 12 hours of continuing education or prorated equivalent. These in-services are offered at hire and three times per year by the HHA Supervisor. Personnel files are being audited daily for this requirement until each file is current. Once the files are current, Personnel will be responsible for auditing the personnel files once a month in order to ensure compliance. The HHA Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>		

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G 229 Bldg. 00	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on review of agency policy, clinical record review, and interview, the agency failed to ensure the registered nurse made supervisory visits of the Home Health Aide (HHA) at least every 2 weeks for 1 of 1 skilled patients also receiving HHA services (3).</p> <p>The findings include:</p> <p>1. Agency policy " Home Health Aide Supervision " , #C-340, copyright Briggs, undated, states " Supervisory visits of Home Health Aides shall be according to the following frequency: a. When skilled services are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client ' s residence at least every two (2) weeks (either when the Home Health Aide is present to observe and assess care delivery, or when the Home Health Aide is absent) to assess relationships and determine whether goals are being met ...</p>	G 229	<p>The Director of Clinical Services in serviced the professional staff (nurses and therapists) of the requirement to document HHA supervision at least every 14 days, This should be included on their progress note Inservices were held on 2/18 and 3/4/2015 The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>	03/17/2015

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G 334 Bldg. 00	<p>b. Other skilled services (Physical Therapy, Speech or Occupational Therapy) but not skilled nursing: Supervision of Home Health Aides may be done by the appropriate Therapist at the client ' s residence at least every two (2) weeks. "</p> <p>2. Clinical record 3, SOC (start of care) 12-12-14, contained a plan of care from 12-12 to 2-9-15 with orders for skilled nursing (SN), physical therapy, occupational therapy, and home health aide services. The clinical record evidenced supervisory visits by the SN on 1-22-15 and no further supervisory visits. The patient was recertified for continued serviced by the Physical Therapist on 2-5-15 but the clinical record failed to evidence a supervisory visit was made at that time.</p> <p>3. On 2-17-15 at 4:00 P.M., the Administrator and Director of Quality indicated the agency policy was not followed for patient 3 during the certification period reviewed.</p> <p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of</p>			

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G 337 Bldg. 00	<p>care.</p> <p>Based on clinical record review and interview, the speech therapist failed to ensure the initial comprehensive assessment (CA) was completed to include vital signs for 1 of 1 admission CA by a speech therapist (1).</p> <p>Findings include:</p> <p>1. Clinical record 1, start of care 12-19-14, included a plan of care for the certification period 12-19-14 to 2-16-15 with orders for speech and occupational therapy. The speech therapist failed to complete the CA to include vital signs in the initial comprehensive assessment dated 12-19-14.</p> <p>2. The Administrator and Director of Quality indicated the comprehensive assessment should include vital signs for every patient. They were unable to provide further documentation demonstrating compliance on 2-17-15 at 4:00 P.M.</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must</p>	G 334	<p>The Director of Clinical Services notified our therapy contracts that when their therapist does the initial visit, that vital signs are a part of the comprehensive assessment and must be included. Our Contractors were notified on 3/2 of this requirement, The Director of Quality Improvement will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur,</p>	03/17/2015	

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	<p>include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review and interview, the physical therapist (PT) failed to ensure the initial comprehensive assessment (CA) included only medications the patient was taking and all the medications the patient was taking (4) for 1 of 1 active patients whose CA was performed by a PT.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During home visit on 2-11-15 at 3:30 PM for patient 4 with speech therapist, the patient indicated he had not been on Coumadin since November 2014, but had been on Cipro since November 2014. 2. Clinical record 4, start of care 1-16-15, contained a plan of care for certification period 1-16 to 3-16-15. The medication profile evidenced Coumadin and failed to evidence Cipro. 3. The Administrator and Director of Quality were unable to provide further documentation demonstrating compliance on 2-17-15 at 4:00 P.M. They stated the 	G 337	<p>The Director of Clinical Services in serviced the therapists on 2/18 and 3/5/2015 to ensure the initial comprehensive assessment includes only medications the patient is taking An RN will review all med lists on patients opened by PT</p> <p>The Director of Quality Improvement will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur,</p>	03/17/2015

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N 000 Bldg. 00	<p>medication profile was not accurate in that it evidenced Coumadin (anticoagulant), which the patient had not been taking since November, 2014, and the medication profile failed to evidence Cipro (antibiotic) which the patient had been taking since November 2014.</p> <p>This visit was for a home health agency state re-licensure survey.</p> <p>Dates of survey: 2-9, 2-10, 2-11, 2-12, 2-13, 2-16, and 2-17-2015</p> <p>Facility #: 012680</p> <p>Medicaid Vendor #: 201083120A</p> <p>Surveyor: Deborah Franco, RN, PHNS</p> <p>Census: Past 12 months: 285 Skilled unduplicated admissions, past twelve months</p>	N 000	Initial comments reviewed 2/28/2015	

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N 472 Bldg. 00	<p style="text-align: right;">48 Home</p> <p>Health Aide only</p> <p style="text-align: right;">15</p> <p>Personal Service only</p> <p style="text-align: right;">348 Total</p> <p>Current Active patients: 88 Skilled, 28 Home Health Aide only, 3 Personal Service only</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: right;">February 24, 2014</p> <p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on policy review, review of the quality assurance and performance improvement plan (QAPI), and interview,</p>	N 472	5% of the personnel files are being audited daily by personnel for completion of skills check off, signed job descriptions, and current professional license, Once we are 100% compliant,	03/17/2015

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N 484	<p>the agency failed to ensure the QAPI collected data using objective measures for 1 of 1 QAPI program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency policy "Performance Improvement", undated, states "Data will be collected to allow Pure Home Health to monitor its performance. Data collection will be prioritized based on the organization's mission, care services provided, and populations served ... data will be systematically collected to measure process and outcome." 2. Review of the 2014 QAPI program failed to evidence data collection using objective measures for the issues "Skills check offs for home health aides", "Job Description", and "Missing Professional License." 3. On 2-17-15-15 at 4:00 PM the Administrator, who supervised the home health aides, was unable to provide further documentation demonstrating compliance. <p>410 IAC 17-12-2(g) Q A and performance improvement</p>		<p>personnel will audit the personnel files for these items once a month to ensure 100% compliance, HR personnel was in-serviced on proper audit procedure of personnel file 2/24/2015 Personnel records will be reviewed in quarterly QA meeting for need for further intervention, The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>		

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Bldg. 00	<p>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 policy review, clinical record review, and interview, the agency failed to ensure the clinical record and/or the minutes of case conferences established that effective interchange, reporting, and coordination of patient care occurred among all personnel rendering services to support the objectives in the patients' plan of care for 2 of 4 active records reviewed (2, 3) of patients receiving more than one of the agency's services.</p> <p>Findings include:</p> <p>1. Agency policy "Coordination of Client Services", C-360, copyright Briggs, undated, states, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal case conferences; maintaining complete, current Care Plans; and written and verbal interaction "</p>	N 484	<p>The Director of Clinical Services and Quality Improvement in-serviced the therapist on 2/18 and 3/4/2015 of the need to document consultation with other agency personnel regarding patient's progress toward goals and outcomes, All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care Communication will be documented on a communication note in the EMR and/or on the case conference record, The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>	03/17/2015

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	<p>2. Clinical record number 2, SOC (start of care) 9-26-14, contained a plan of care from 9-26 to 11-24-14 with orders for physical therapy and occupational therapy. The clinical record and the minutes of case conferences failed to evidence communication and / or coordination of care between the two disciplines. Agency case conferences during the certification period conducted on 10-15 and 10-29-14 failed to include documentation of the patients who were the subject of the conferences and the effective interchange, reporting, and coordination of patient care.</p> <p>3. Clinical record 3, SOC (start of care) 12-12-14, contained a plan of care from 12-12 to 2-9-15 with orders for skilled nursing, physical therapy, occupational therapy, and home health aide services. The clinical record and the minutes of case conferences failed to evidence communication and / or coordination of care between the three disciplines during the certification period. One communication note between PT and OT only dated 2-11-15 was in the clinical record. Agency case conferences during the certification period conducted on 1-21 and 2-4-15 failed to include documentation of the patients who were the subject of the conferences.</p>			

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N 518 Bldg. 00	<p>4. On 2-17-15 at 4:00 PM, the Administrator indicated the agency policy permits the use of informal communication by telephone or email among the disciplines, as well as clinical record and case conferences, to accomplish coordination of patient care in addition to clinical record and minutes of case conferences. Upon request, the Administrator was unable to provide any further documentation demonstrating compliance prior to exit.</p> <p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on document review, clinical record review, and interview, the agency failed to ensure patients were provided the current Indiana Advance Directives, including a description of applicable State law, in 12 of 12 records reviewed (1 - 12) with the potential to affect agency's current 19 patients.</p> <p>Findings include:</p>	N 518	The Admission Packets were updated to include the revised July 1, 2013 advanced Directive on 2/9/2015 The nurses were given a copy of the revised directive at case conference on 2/18/2015 to give to our existing patients, The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	03/17/2015

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	<p>1. The admission package given to agency patients failed to include the state of Indiana Advanced Directives revised July 1, 2013. The admission packet contained a state of Indiana Advance Directive brochure from May 2004.</p> <p>2. Clinical record 1, start of care (SOC) 12-19-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p> <p>3. Clinical record 2, SOC 9-28-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p> <p>4. Clinical record 3, SOC 12-12-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. During home visit on 2-11-15 at 11:30 A.M. the patient's home packet was observed to contain Advance Directive description of Indiana law dated 5-2004; this version failed to describe the physician's order scope of treatment advance directive option.</p> <p>5. Clinical record 4, SOC 1-16-15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. During home visit on 2-11-15 at 3:30 A.M. the patient's home packet</p>			

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	<p>was observed to contain Advance Directive description of Indiana law dated 5-2004; this version failed to describe the physician's order scope of treatment advance directive option.</p> <p>6. Clinical record 5, SOC 12-26-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. During home visit on 2-12-15 at 11:00 A.M. the patient's home packet was observed to contain Advance Directive description of Indiana law dated 5-2004; this version failed to describe the physician's order scope of treatment advance directive option.</p> <p>7. Clinical record 6, SOC 5-30-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p> <p>8. Clinical record 7, SOC 4-15-13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. Patient start of care was prior to the 7-2013 revision of Indiana Advance Directive law.</p> <p>9. Clinical record 8, SOC 9-15-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p>			

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	<p>10. Clinical record 9, SOC 8-4-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p> <p>11. Clinical record 10, SOC 7-2-14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p> <p>12. Clinical record 11, SOC 12-22-13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p> <p>13. Clinical record 12, SOC 10-31-13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p> <p>14. The Administrator indicated on 2-17-15 at 4:00 PM the agency failed to notify patients of their Advance Directive rights to include a description of current Indiana Advance Directives for all patients admitted after 7-1-13, and failed to update all active patients receiving agency services prior to that date regarding their Advance Directive rights as per Indiana Advance Directives brochure of July 1, 2013. The Administrator indicated the agency failed to change its admission packet when the Advance Directive brochure was updated.</p>			

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N 522 Bldg. 00	<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 policy review, clinical record review, and interview, the agency failed to ensure visits were made as ordered on the Plan of Care (POC) in 4 of 12 clinical records reviewed (3, 5, 7, and 11) with the potential to affect all the agency's current 119 patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency policy "Plan of Care", copyright Briggs, undated, states, "Home care services are furnished under the supervision and direction of the client's physician ... The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every sixty (60) days." 2. Clinical record 3, start of care (SOC) 12-12-14, contained a physician's plan of care for certification period 12-12-14 to 2-9-15 with orders for physical therapy 	N 522	<p>The Director of Clinical Services in-serviced professional staff on 2/18 and 3/4/2015 of the need to follow the visits as ordered on the Physician's Plan of Care The Director of Quality Improvement will ensure that the Clinical record shows evidence that the physician was notified of missed visits Orders will be sent to the physician to discontinue service earlier than anticipated, The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>	03/17/2015

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	<p>(PT) "2W9" (2 times a week for 9 weeks). The record failed to evidence the PT followed the POC to include making visits 2 times a week during the weeks of 12-21-to 12-17-14 (1 visit); 12-28-14-to 1-3-15 (1 visit), and 1-11- to 1-17-15 (1 visit). The clinical record failed to evidence the physician was notified of these missed PT visits. The POC included orders for skilled nursing 2W1, 1W8 (2 times a week for one week, 1 time a week for 8 weeks). The clinical record failed to evidence visit notes for skilled nursing after 1-22-15 and failed to evidence an order from the physician to discontinue skilled nursing prior to the end of the certification period. The last nursing visit note on 1-22-15 indicated patient's nursing goals had been met.</p> <p>3. Clinical record 5 , SOC 12-26-14, contained a physician's plan of care for certification period 12-26-14 to 2-23-15 including orders for skilled nursing (SN) 2W9. The record failed to evidence the SN followed the POC to include making visits 2 times a week during the weeks of 12-28-14 to 1-3-15 (1 visit), 1-4 to 1-10-15 (1 visit), and 1-25 to 1-31-15 (1 visit). The clinical record failed to evidence the physician was notified of these missed visits.</p> <p>4. Clinical record 7, SOC 4-15-13,</p>			

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	<p>contained a plan of care for the certification period 12-6-14 to 2-3-15 with orders for home health aide (HHA) services 3 times a week for 9 weeks. During the certification period, the clinical record evidenced HHA visits 2 times a week. The clinical record failed to evidence an interim order modifying the HHA visit frequency.</p> <p>5. Clinical record 11, SOC 12-22-13, contained a physician's plan of care for certification period 8-19 to 10-17-14 with orders for SN 2W8 and PT 2W4. The record failed to evidence the PT followed the POC to include making visits 2 times a week during the week of 9-28-to 10-4-13 (1 visit); and failed to evidence the SN followed the POC to include making 2 visits the week of 8-31 to 9-6-13. The record failed to evidence the physician was notified of the missed visits.</p> <p>6. On 2-17-15 at 4:00 PM, the Administrator and Director of Quality indicated the plans of care had not been followed as ordered by the patients' physicians and the agency policy had not been followed.</p>			

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	<p>records were reviewed and 2 of 6 patients (1, 2) with clinical records review only, and failed to ensure the plan of care accurately reflected the medications the patient was taking for 1 of 6 home visits (4) whose clinical records were reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency policy, "Plan of Care", copyright Briggs, undated, states "The Plan of Care shall be completed in full to include: ... medications, treatments, and procedures ... medical equipment and supplies ... " During home visit on 2-11-15 at 11:30 AM of patient 3, start of care (SOC) 12-12-14, a rolling walker was observed in the home, which the patient said he/she uses, but was not listed on the plan of care (POC) for the certification period 12-12-14 to 2-9-15. During home visit on 2-12-15 at 11:00 AM of patient 7, SOC 4-15-13, a rolling walker, shower chair, and grab bars were observed in the home, which the patient said he/she uses, but were not listed on the POC for the certification period 12-6-14 to 2-3-15. Clinical record 1, SOC 12-19-14, contained a plan of care for the 		<p>is needed and all medications the patient is on must be included on the plan of care, An RN will review the med profile on patients opened by a therapist, The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>	

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	<p>certification period 12-19-14 to 2-16-15 with orders for occupational therapy and speech language therapy. SOC comprehensive assessment dated 12-19-14 noted the patient used a cane but the plan of care failed to evidence a cane as durable medical equipment.</p> <p>5. Clinical record 2, SOC 9-26-14, contained a plan of care for the certification period 9-26 to 11-24-14 with orders for physical therapy and occupational therapy. The SOC comprehensive assessment noted the patient used a walker but the plan of care failed to evidence the walker as durable medical equipment.</p> <p>6. During home visit on 2-11-15 at 3:30 PM, patient 4 indicated he had taken Cipro since discharge from rehabilitation hospital and was still taking it for a urinary tract infection. The patient indicated he was not taking Coumadin. Clinical record 4, SOC 1-16-15, contained a plan of care for the certification period 1-16-15 to 3-16-15 including orders for physical therapy and speech language therapy. The plan of care failed to include the Cipro and included Coumadin. There were no interim orders to update the medications in the clinical record.</p>			

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N 529 Bldg. 00	<p>7. During home visit for patient 6 on 2-12-15 at 2:30 P.M., a rolling walker and shower chair were observed in the home. The clinical record, SOC 5-30-14, contained a plan of care for certification period 1-25 to 3-25-15 which failed to evidence the rolling walker and shower chair as durable medical equipment.</p> <p>8. During home visit of patient 8 on 2-16-15 at 2:00 P.M., SOC 1-13-15, a rolling walker, shower chair, cane, and wheelchair were observed in the home, which the patient said he/she uses (except the wheelchair) the equipment, but they were not listed on the POC for the certification period 1-13 to 3-13-15.</p> <p>9. The Alternate Administrator indicated on 2-17-15 at 4:00 PM, the agency policy had not been followed for the above clinical records.</p> <p>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.</p> <p>Based on clinical record review and interview, the agency failed to ensure that</p>	N 529	The Director of Quality Improvement in-serviced the professional staff of nurses and therapists on 2/18 and 3/4/2015	03/17/2015

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	<p>a written summary report was sent to the patient's attending physician at least every 60 days for 1 of 7 active (3) and 1 of 5 closed clinical records (2) with the potential to affect all of the agency's patients receiving home health services for greater than 60 days (3, 6, 7, and 8).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 3, start of care (SOC) 12-12-14, receiving physical therapy, occupational therapy, and home health aide services, failed to evidence a 60 day written summary report was sent to the patient's physician at the end of the certification period reviewed 12-12-14 to 2-9-15. 2. Clinical record 2, SOC 9-28-14, receiving skilled nursing, physical therapy, and occupational therapy services, failed to evidence a 60 day written summary report was sent to the patient's physician at the end of the certification period reviewed 9-26 to 11-24-14. 3. Upon request, the Administrator and the agency's Quality Director, on 2-17-15 at 4:00 P.M., were unable to provide additional documentation to evidence compliance. 		<p>regarding where to access Plan of Care Summaries in the EMR They were instructed to prepare a written summary report to be sent to the patient's attending physician every 60 days, The Director of Quality Improvement will be responsible for auditing the chart every 60 days for compliance with plan of care summaries, The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>	

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N 537 Bldg. 00	<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 interview, the skilled nurse failed to ensure skilled nursing services were furnished as ordered on the plan of care (POC) for 1 of 4 active patients (3) receiving skilled nursing care.</p> <p>Findings include:</p> <p>1. Clinical record 3, SOC (start of care) 12-12-14, contained a POC from 12-12 to 2-9-15 with orders for skilled nursing 2W1, 1W8 [2 times a week for one week and 1 time a week for 8 weeks]. The clinical record failed to evidence visit notes for skilled nursing after 1-22-15 and failed to evidence an order from the physician to discontinue skilled nursing prior to the end of the certification period. The last nursing visit note on 1-22-15 indicated patients nursing goals had been met.</p> <p>2. On 2-17-15 at 4:00 P.M. the Nursing Supervisor indicated patient 3's physician should have been contacted for an order to discontinue skilled nursing services earlier than the order on the plan of care.</p>	N 537	The Director of Clinical Services and Quality Improvement in serviced the nurses on 2/18 and 3/4/2015 of the nurses responsibility to Coordinate Care and to furnish services according the POC. Whenever nursing discharges before therapy, she must document communication in the EMR that all personnel are aware of the nursing discharge, A verbal must be obtained from Physician for early discharge, The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,	03/17/2015

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N 545 Bldg. 00	<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 review and interview, the skilled nurse failed to coordinate services between skilled nursing, physical therapy, and occupational therapy, and home health aide for 1 of 2 active clients (3) receiving skilled nursing care and other services.</p> <p>Findings include:</p> <p>1. Clinical record 3, SOC (start of care) 12-12-14, contained a POC from 12-12 to 2-9-15 with orders for skilled nursing (SN), physical therapy (PT), occupational therapy (OT), and home health aide services. The clinical record failed to evidence visit notes for skilled nursing after 1-22-15 and failed to evidence communication to the other disciplines that SN was discharging the patient from SN services prior to the plan of care order. The last nursing visit note on</p>	N 545	<p>The Director of Clinical Services in-serviced the nurses on 2/18 and 3/4/2015 of nursing's responsibility to coordinate care, The Skilled Nurse must document that they have communicated to the other disciplines that SN is discharging the patient from SN services prior to the plan of care order, Communication between the disciplines shall be included in the minutes of the case conference, and/or in communication notes which are a part of the EMR The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,</p>	03/17/2015

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N 566 Bldg. 00	<p>1-22-15 indicated patient's nursing goals had been met. The minutes of case conferences failed to evidence communication and / or coordination of care between the 4 disciplines during the certification period. One communication note dated 2-11-15 between PT and OT only was in the clinical record. Agency case conferences during the certification period conducted on 1-21 and 2-4-15 failed to include documentation of the patients who were the subject of the conferences.</p> <p>2. On 2-17-15 at 4:00 P.M. the Nursing Supervisor indicated patient 3's physician should have been contacted for an order to discontinue skilled nursing services earlier than the order on the plan of care.</p> <p>410 IAC 17-14-1(c)(5) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (5) prepare clinical notes;</p> <p>Based on clinical record review and interview, the agency failed to ensure the therapist submitted visit notes timely after completing a visit for 1 of 4 records reviewed of patients receiving therapy services (1) creating the potential to</p>	N 566	The Director of Clinical Services notified our two therapy companies that we must receive written progress notes on a weekly basis,3/2/2015. Medical Records will be responsible for ensuring that we have received their notes timely and for	03/17/2015

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N 567 Bldg. 00	<p>affect all patients receiving therapy services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record 1, SOC 12-19-14, included a plan of care established by the physician for the certification period 12-19-14 to 2-16-15 with orders for speech language therapy and occupational therapy. The clinical record failed to evidence visit notes after 12-30-14 for speech language therapy visits. The Administrator and Director of Quality were unable to provide further documentation demonstrating compliance on 2-17-15 at 4:00 P.M. <p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel;</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the therapists advised and consulted with other agency personnel regarding patients' progress toward goals and outcomes for 2 of 7 records reviewed (2, 3) of patients receiving therapy services.</p>	N 567	<p>scanning them in to the EMR on a weekly basis, The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will recur,</p> <p>The Director of Clinical Services in-serviced the therapists on how to include written communication notes into the EMR and case conference notes documenting consultation with other agency personnel regarding patients' progress toward goals and outcomes of patients receiving therapy services, An in-service was held on 2/18 and 3/4/2015, The Director of Quality</p>	03/17/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Agency policy "Coordination of Client Services", C-360, copyright Briggs, undated, states, "All personnel furnishing services shall maintain a liaison to assure that their efforts coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal case conferences; maintaining complete, current Care Plans; and written and verbal interaction " 2. Clinical record 2, SOC (start of care) 9-26-14, contained a plan of care from 9-26 to 11-24-14 with orders for physical therapy and occupational therapy. The clinical record failed to evidence communication and / or coordination of care between the two therapists regarding the patient ' s progress toward goals and outcomes. Agency case conference meeting minutes during the certification period conducted on 10-15 and 10-29-14 failed to include the names of the patients who were the subject of the conferences and failed to evidence the attendance of any occupational therapist at the case conference meetings. 3. Clinical record 3, SOC 12-12-14, contained a plan of care from 12-12 to 2-9-15 with orders for skilled nursing, 		Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,	

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	<p>physical therapy, occupational therapy, and home health aide services. The clinical record failed to evidence communication and / or coordination of care between the two therapists regarding the patient ' s progress toward goals and outcomes. Agency case conference meeting minutes during the certification period conducted on 1-21-15 and 2-4-15 failed to include the names of the patients who were the subject of the conferences and failed to evidence the attendance of any occupational therapist at the case conference meetings.</p> <p>4. On 2-17-15 at 4:00 P. M., the Administrator indicated the agency policy permits the use of informal communication by telephone or email among the disciplines, as well as clinical record and case conferences, to accomplish coordination of patient care in addition to clinical record and minutes of case conferences. These informal communications are not retained as part of the clinical record or the case conference meeting minutes. Upon request, the Administrator was unable to provide any further documentation demonstrating the therapists advised and consulted with other agency personnel regarding patients 2 and 3 during the certification periods reviewed.</p>			

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N 586 Bldg. 00	<p>410 IAC 17-14-1(h) Scope of Services Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas:</p> <p>(1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff.</p> <p>(2) Observing, reporting, and documenting patient status and the care or service furnished.</p> <p>(3) Reading and recording temperature, pulse, and respiration.</p> <p>(4) Basic infection control procedures and universal precautions.</p> <p>(5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.</p> <p>(6) Maintaining a clean, safe, and healthy environment.</p> <p>(7) Recognizing emergencies and knowledge of emergency procedures.</p> <p>(8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property.</p> <p>(9) Appropriate and safe techniques in personal hygiene and grooming that include the following:</p> <p>(A) Bed bath.</p> <p>(B) Bath; sponge, tub or shower.</p> <p>(C) Shampoo, sink, tub, or bed.</p> <p>(D) Nail and skin care.</p> <p>(E) Oral hygiene.</p>						

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	<p>(F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform.</p> <p>Based on review of job description, personnel file review, and interview, the agency failed to ensure home health aides (HHA) received 12 hours of continuing education, or prorated equivalent, for 1 of 8 HHA personnel files reviewed (N).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency job description, copyright Briggs, undated, for HHA states, "Attends in-service programs to meet compliance requirements." Personnel files for HHA Employee N, date of hire 11/21/13, failed to evidence 12 hours of continuing education, or prorated equivalent for 2014. The employee personnel file failed to evidence any documentation of continuing education in 2014. On 2-17-15 at 4:00 PM, upon request, the Alternate Director of Nursing, who supervised the HHAs, was 	N 586	An Audit tool has been added to the front of our personnel files which includes the 12 hours of continuing education or prorated equivalent. These in-services are offered at hire and three times per year by the HHA Supervisor. Personnel files are being audited daily for this requirement until each file is current. Once the files are current, Personnel will be responsible for auditing the personnel files once a month in order to ensure compliance. The HHA Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,	03/17/2015

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N 597 Bldg. 00	<p>unable to provide further documentation demonstrating compliance.</p> <p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on personnel record review and interview, the agency administrator failed to ensure home health aides were registered and in good standing on the state aide registry for 5 of 6 aide (K, L, M, N, O) personnel files reviewed creating the potential to affect all patients who were receiving home health aide services in the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel record K, a home health aide, date of hire 7-25-13 and first patient contact 9-24-13, failed to evidence the agency had determined the aide was in good standing and on the state registry prior to providing patient care. 2. Personnel record L, a home health aide, date of hire 3-26-13 and first patient contact 3-27-13, failed to evidence the agency had determined the aide was in good standing and on the state registry prior to providing patient care. 	N 597	Personnel files are being audited on a daily basis until personnel files are current to ensure that all of our home health aides are qualified by confirming the home health aides are registered and in good standing on the state aide registry All new hires will be confirmed on the state aide registry prior to starting patient care, This is a part of our QAPI initiative begun on 1/5/2015 The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,	03/17/2015

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	<p>3. Personnel record M, a home health aide, date of hire 5-12-14 and first patient contact 5-14-14, failed to evidence the agency had determined the aide was in good standing and on the state registry prior to providing patient care.</p> <p>4. Personnel record N, a home health aide, date of hire 11-21-13 and first patient contact 11-23-13, failed to evidence the agency had determined the aide was in good standing and on the state registry prior to providing patient care.</p> <p>5. Personnel record O, a home health aide, date of hire 7-14-14 and first patient contact 7-19-14, failed to evidence the agency had determined the aide was in good standing and on the state registry prior to providing patient care.</p> <p>6. The Administrator indicated on 2-17-14 at 4:00 PM the agency had completed competency testing on the above aides and thought the agency had completed the registration of these personnel. The Administrator was not able to provide further documentation demonstrating compliance prior to exit and indicated the staff did not have any specific recollection of when the application for registration may have</p>			

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N 606 Bldg. 00	<p>been sent to Indiana State Department of Health. The Administrator indicated the agency has started a performance improvement plan on 1-5-14 regarding the creation and maintenance of personnel files in accordance with regulation, rules, and agency job descriptions.</p> <p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse made supervisory visits of the Home Health Aide (HHA) at least every 30 days for 1 of 1 (7) unskilled patients receiving HHA services and every 2 weeks for 1 of 1 skilled patient also receiving HHA services (3)..</p> <p>The findings include:</p> <p>1. Clinical record 7, start of care 4-15-13, contained a plan of care for the certification period 12-6-14 to 2-3-15 with orders for HHA services 3 times a</p>	N 606	The Director of Clinical Services in-serviced the professional staff (nurses and therapists) of the requirements to document HHA supervision at least every 14 days on skilled cases and every 30 days on HHA only cases On Skilled cases, they are to document the supervision on a skilled note, On an aide only case, a supervisory visit is scheduled and this note is used for supervision documentation, The Director of Quality Improvement will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur,	03/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157645	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2015
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NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9333 N MERIDIAN STREET SUITE 104 INDIANAPOLIS, IN 46260
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	<p>week for 9 weeks. HHA visits were made from 12-6-14 to 2-2-15. Supervisory visits by SN were on 12-13-14 and 1-30-15; 48 days after the previous supervisory visit.</p> <p>The Administrator and Director of Quality were unable to provide further documentation demonstrating compliance on 2-17-15 at 4:00 P.M.</p> <p>2. Clinical record 3, SOC (start of care) 12-12-14, contained a plan of care from 12-12 to 2-9-15 with orders for skilled nursing (SN), physical therapy, occupational therapy, and home health aide services. The clinical record evidenced supervisory visits by the SN on 1-22-15 and no further supervisory visits. The patient was recertified for continued serviced by the Physical Therapist on 2-5-15 but the clinical record failed to evidence a supervisory visit was made at that time.</p> <p>A. On 2-17-15 at 4:00 P.M., the Administrator and Director of Quality indicated the agency policy was not followed for patient 3 during the certification period reviewed.</p> <p>B. Agency policy " Home Health Aide Supervision " , #C-340, copyright Briggs, undated, states " Supervisory</p>			

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	visits of Home Health Aides shall be according to the following frequency: a. When skilled services are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client ' s residence at least every two (2) weeks (either when the Home Health Aide is present to observe and assess care delivery, or when the Home Health Aide is absent) to assess relationships and determine whether goals are being met ... b. Other skilled services (Physical Therapy, Speech or Occupational Therapy) but not skilled nursing: Supervision of Home Health Aides may be done by the appropriate Therapist at the client ' s residence at least every two (2) weeks. "			