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	157593	A. BUILDING 00 B. WING	06/30/2014

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G000000	This was a home health agency recertification survey which resulted in an extended survey. Survey Dates: June 24, 25, 26, 27, and 30, 2014 Facility #: 010480 Medicaid Vendor #: 200863280 Surveyor: Bridget Boston, RN, PHNS Mulberry Community Health Services is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning June 30, 2014, through June 30, 2016, for being found out of compliance with the Conditions of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision and 484.48 Clinical records. Quality Review: Joyce Elder, MSN, BSN, RN July 7, 2014	G000000	Submission of this plan of correction and credibleallegation of compliance does not constitute an admission by the certified andlicensed provider at Mulberry Community Health Services that the allegationscontained in the survey report are true and accurate portrayal of theprovisions of nursing care and other services at this healthcare agency. The agency recognizes its obligation toprovide legally and medically required services to its patients in an economicand efficient fashion. The agency herebymaintains that it is in substantial compliance with Federal participatingrequirements for home health agency participating in the Medicareprograms. As a result, this plan ofcorrection constitutes an allegation of compliance of Federal and Stateregulations. Mulberry Community Health Services respectfully requests a Desk Review in lieu of a Post Survey revisit on or after July 30, 2014.	
G000121	484.12(c) COMPLIANCE W/ ACCEPTED			

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

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	PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation and interview, the agency failed to ensure the home health aide followed standard infection control practices for 1 of 1 (4) home health aide visits observed resulting in the potential for patient harm and the potential to affect all current 9 patients receiving home health aide services. (Employee G) Findings: 1. On 6/26/14 at 8 AM, a bed bath was observed in the home of patient 4 performed by home health aide employee G. The patient is currently receiving treatment for Breast Cancer and is immune suppressed. The patient resides in a private residence with a caregiver and has a single hospital bed located in a bedroom. Employee G was observed to provided hygiene care and a bed bath while wearing non - traditional gloves throughout the bath. the gloves appeared to be food prep gloves. She changed her gloves prior to providing care to the perineal area and then continued to dress the patient and handle the E - Z lift while wearing the same gloves. A. Employee G was then	G000121	No correction can be done on the incident due to the time frame of the HHA following standard of infection control practices on patient 4. Administrator and Clinical Supervisor conducted education, coaching, counselingand established a performance improvement plan for employee G on infection control policy and procedures, hand washing, gloving, housekeeping practices and clinical supply bag audit on 07.01.14. Employee G will also be observed randomly at clients' home on infection control procedures, hand washing, gloving, housekeeping practices and bag audit 4 x in 1 month and will continue unless 100% compliancefor 3 consecutive audits/observations starting 07.01.14. Administrator and/or Clinical Supervisor will completethe in-service to all nurses, therapists and home health aides on the following: infection control policy and procedures, handwashing, gloving, housekeeping practices and bag techniques of the Home Health agency by 07.30.14. Administrator or designee will randomly audit/observe HHAs while providing care 50% of the total client having HHA services	07/30/2014

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	observed to complete care and propel the patient to a main area of the home and then completed hand hygiene. The patient's E - Z lift was not decontaminated following care. B. When asked, employee G indicated the gloves were not the ones provided by the agency. She indicated she brought them herself and brought the wrong ones for home care stating, "They are not latex." 2. The administrator indicated on 6/26/14 at 3 PM, the observation described was not appropriate and that latex or approved gloves were to be worn while providing care to the patients.		for 1 monthand 10% in the next 3 months, or 100% compliance for 2 consecutive months on infection control, Hand washing, gloving and housekeeping practices starting07.01.14. Ongoing, the Clinical Supervisor or designee will observe Home HealthAides at least once a month for 6 months. The agency will utilize an outside provider that will conduct Annual Home Health Aide skill check offs to all Home Health Aides and will be completed by 07.30.14 It will be the responsibility of the Administrator or designees to monitor that these corrective actions are followed and ensure that this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	
G000156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on interview and review of clinical records and policy, it was determined the agency failed to ensure the medical care provided to the patient followed the medical plan of care as established by the physician and the attending physician was consulted and orders were obtained prior to the provision of skilled care in 5 of 11 current clinical records reviewed with the potential to affect all current 28	G000156	Administrator and/or Clinical Supervisor will complete the in-service to all nurses, therapists, and home health aides on following: Physician Orders, and Medical Plan of CarePolicy, and Procedures of the Home Health agency by 07.30.14. It will be the responsibility of all clinicians who are doing a specific discipline assessment to report to the Clinician performing the OASIS through the specific discipline Assessment Summary Form and convey the result of the	07/30/2014

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	patients (See G 158); failed to ensure plans of care included all medications, treatments, and services in 5 of 11 current records reviewed creating the potential to affect all 28 patients receiving services within the agency (See G 159); and failed to ensure all personnel providing care participated in the development of the patient's written plan of care in 4 of 11 clinical records reviewed of patients receiving therapy services (See G 162). The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.		evaluation done to be included on the Plan of Care effective 07.01.14. Administrator or designee will audit 100% of admissions for 2 weeks; 50% for the succeeding 2 weeks; 25% for 2 consecutive weeks until 100% compliance starting 07.01.14. It will be the responsibility of the Administrator or designee to continue to monitor through discussing patients status and plan ofcare during weekly meetings to ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	
G000158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on interview and review of clinical records and policy, the agency failed to ensure the medical care provided to the patient followed the medical plan of care as established by the physician and the attending physician was consulted and orders were obtained prior to the	G000158	No correction can be done due to the time frame for the incomplete lab draws order on 05.20.14; 06.09.14; 06.16.14 on Clinical record 4 showing on the Plan of Care. Administrator conducted counseling with RN (employee A and D) and PT/OT on following plan of care established by the	07/30/2014

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	provision of skilled care in 5 of 11 current clinical records reviewed with the potential to affect all current 28 patients. (4, 6, 7, 9, and 10) Findings: 1. Clinical record 4, start of care (SOC) 3/5/14, included a plan of care for the certification period 5/4/14 to 7/2/14 with orders for skilled nurse two times a week for eight weeks, then once a week for the last week and "draw labs per physician orders." A. Skilled nurse visit note dated 5/20/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. B. Skilled nurse visit note dated 6/9/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. C. Skilled nurse visit note dated 6/16/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. D. On 6/30/14 at 4 PM,		physician and specificity of orders to be included on the Plan of Care on 07.01.14. No correction can be done due to the time frame for not including the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing for client 6 on the Plan of Care. Administrator conducted counseling with RN (employee A and D) and PT/OT on following plan of care established by the physician and specificity of orders on 07.01.14. It will be the responsibility of all clinicians who are doing a specific discipline assessment to report to the Clinician performing the OASIS through the specific discipline Assessment Summary Form and convey the result of the evaluation done to be included on the Plan of Care effective 07.01.14. Administrator and/or Clinical Supervisor will complete the in-service to all nurses, therapists, and home health aides on following: Physician Orders Policy and Procedures of the Home Health agency by 07.30.14. Starting 07.01.14; Administrator or designee will do chart audits 100% of all SOC for 2 weeks; 50% for the next 2 weeks and 20% for 2 consecutive weeks for 100% compliance in order to ensure that the Medical Plan of Care established by Physician and the Attending Physician was consulted, and orders were	

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	employee A indicated the order for the laboratory draws was dated 4/29/14 and the current plan of care did not specify the laboratory orders. 2. Clinical record 6, SOC 6/23/14, included a medical plan of care for the certification period 6/23/14 to 8/21/14 with orders for skilled nurse once a week for 4 weeks for wound care with bacitracin ointment to be applied topically to left shin wound, cover with adherent dressing, wrap with kerlex and secure with tape daily. In addition, under DME (durable medical equipment) and supplies were listed the medication calcium alginate silver and normal saline and the dressing mepilex foam border dressing. The plan of care failed to evidence the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing. A. On 6/30/14 at 1:20 PM, employee D indicated, when asked, she did not have a physician order to provide wound care as documented on the comprehensive assessment. She indicated she wrote a request to the physician for the wound care orders following the assessment and provision of care. She indicated the wound care provided on 6/23/14 as documented was		obtained prior to the provision of skilled care. It will be the responsibility of the Administrator or designee to continue to monitor through discussing patients status and plans of care during weekly meetings to ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	

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	from the patient's supplies of calcium alginate silver, normal saline, and the dressing mepilex foam border. She indicated the patient had used these for the similar wounds prior to to the stay in the extended care facility and, therefore, she provided wound care with the same medications and then sent a request to the physician to change the treatment orders. A physician order dated 6/23/14 stated, "Wound care to LLE stasis ulcers ... apply silvadene topically to LLE [left lower extremity] - place silver alginate to open ulcers, cover with mepilex foam border dressing ... d/c [discontinue] bacitracin to LLE." B. The plan of care for the certification period beginning 6/23/14 had orders that stated, "Physical Therapy [physical therapy] to evaluate and treat per PT POC [plan of care] and Occupational Therapy [OT] to evaluate and treat per OT POC." The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 6/23/14. The POC failed to evidence the OT and PT treatments and services to be provided and the patient's therapy related goals. 3. Clinical record 7, SOC 5/19/14, evidenced a medical plan of care for the			

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	certification period 5/19/14 through 7/17/14 with orders for PT twice a week for four weeks. The record evidenced OT evaluated and began providing services on 5/20/14. OT services were provided on 5/22/14 and 5/26/14. The record failed to evidence orders from the attending physician were received for OT services until 5/27/14. 4. Clinical record 9, SOC 5/19/14, included a plan of care for the certification period 5/19/14 to 7/17/14 with orders for skilled nurse twice a week for the first 4 weeks and then three times a week for the next 3 weeks of the certification period. The clinical record failed to evidence three skilled nurse visits were made as ordered during week five of the certification period. Documentation evidenced skilled nurse visits were made on June 10 and 12 during week four, on June 17 during week five, and June 24 during week six, and the patient was discharged from skilled nurse services on 6/24/14. 5. Clinical record # 10, start of care 6/9/14, included a medical plan of care for the certification period 6/9/14 through 8/7/14 with orders for skilled nurse services twice a week for the first 3 weeks and then once for the forth week and PT and OT to evaluate and treat per			

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	their plans of care. A. The clinical record evidenced the PT and OT evaluated on 6/9/14 and each discipline provided the first therapy treatment at the time of the evaluation. The clinical record failed to evidence specific verbal or written physician orders, prior to the provision of care, for the treatments and services provided on 6/9/14. B. A communication document dated 6/9/14 written by employee A indicated the patient was evaluated for PT services admitted for PT services. C. A communication document dated 6/9/14 written by employee B to the attending physician, indicated the patient was evaluated and admitted for OT services on 6/9/14. The communication was written on 6/10/14. D. On 6/30/14 at 1 PM, employee A indicated the disciplines do not call the attending prior to the provision of care. He indicated the "admit and treat for services as indicated" was the agency's order to treat patients. E. Review of the policy titled "Physician Orders" approval date 3/27/14, states, "All treatment and care			

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	must be ordered, dated, and signed by the physician ... The orders may be initiated by telephone or in writing ... 6. A copy of the order must be placed in the chart until the original is signed ... All physician orders shall be maintained in the clinical record." 6. On 6/30/14 at 3:06 PM, employee A indicated there was no other documentation to evidence.			
G000159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all medications, treatments, and services in 5 of 11 current records reviewed creating the potential to affect all 28 patients receiving services within the agency. (#	G000159	Administrator conducted counseling with PT and OT on ensuring plans of care include all medication, treatments, and services on 07.01.14. PT and OT evaluation dated 05.22.14 and signed by MD as part of comprehensive plan of	07/30/2014

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	2, 5, 6, 10, and 12) Findings include: 1. Clinical record 2, start of care (SOC) 5/22/14, included a plan of care for the certification period 5/22/14 through 7/20/14 that stated, "Physical therapy [PT] to evaluate and treat per PT POC [plan of care]. Occupational Therapy [OT] to evaluate and treat per OT POC ... Goals / Rehabilitation Potential / Discharge Plans. ... 3. Client's gait will improve as evidenced by 5 - 10 steps using a standards walker with minimum to moderate assistance X 1 [one time] thru 06282014. ... Standing tolerance for 5 minutes in preparation for gait training if appropriate. ... Client will be able to make 5 steps using standard walker with min - moderated assistance X 1." A. The record evidenced the comprehensive assessment was completed by a physical therapist and included the description of three stasis ulcers and stated, "Will call Dr. [name] if he is agreeable for MIST therapy to facilitate wound closer." The POC failed to evidence the patient had wounds, the treatment orders, and who was caring for them. B. The record evidenced the OT		care for Clinical Record 2. No correction can be done due to the time frame for not including the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing for client 6 on the Plan of Care. Administrator conducted counseling with RN (employee A and D) and PT/OT on following plan of care established by the physician and specificity of orders on 07.01.14. PT and OT evaluation dated 06.09.14 and signed by MD as part of comprehensive plan of care for Clinical Record 10. It will be the responsibility of all clinicians who are doing a specific discipline assessment to report to the Clinician performing the OASIS through the specific discipline Assessment Summary Form and conveythe result of the evaluation done to be included on the Plan of Care effective 07.01.14. Administrator and/or Clinical Supervisor will complete the in-service to all nurses, therapists and home health aides on Medical Plan of Care Policy and Procedure by 07.30.14. Starting 07.01.14; Administrator or designee will do chart audits 100% of all SOC for 2 weeks;	

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	evaluated the patient on 5/22/14. The plan of care failed to evidence the treatments and services to be provided by the occupational therapist and the patients goals as related to OT. C. During a home visit on 6/25/14 at 8:30 AM, the patient was observed to be wheelchair bound. The caregiver and patient were interviewed and indicated the patient was transferred between surfaces with maximum assistance of one individual that is capable of weight bearing assistance; the patient was not capable of transferring self, not standing, or ambulation. 2. Clinical record 5, start of care 4/24/14, included a medical plan of care with orders for skilled nurse once a week for 4 weeks, and "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 4/24/14. The POC failed to evidence the OT and PT treatments, services to be provided, and the patient's goals. 3. Clinical record 6, SOC 6/23/14, included a medical plan of care for the certification period 6/23/14 which included orders for skilled nurse once a		50% for the next 2 weeks and 20% for 2 consecutive weeks until 100% compliance in following plans of care included all medications, treatments, and services . It will be the responsibility of the Administrator or designee to continue to monitor through discussing patients status and plan of care during weekly meetings to ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	

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	week for 4 weeks for wound care. The plan of care was not clear what the treatment order was to be for the wounds on the left shin areas. The plan of care included orders for bacitracin ointment to be applied topically to left shin wound, cover with adherent dressing, wrap with kerlex, and secure with tape daily. In addition, under DME (durable medical equipment) and supplies, the medication calcium alginate silver and normal saline and the dressing mepilex foam border dressing was listed. The plan of care failed to evidence the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing. A. The plan of care for the certification period 6/23/14 with orders that stated, "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 6/23/14. The POC failed to evidence the OT and PT treatments, services to be provided, and the patient's related therapy goals. B. The plan of care included orders for Humalog Insulin per sliding scale and bacitracin ointment to the left shin areas. The physician order dated			

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	6/23/14 discontinued the insulin due to the patient did not use the insulin and discontinued the bacitracin ointment. 4. Clinical record # 10, start of care 6/9/14, included a medical plan of care for the certification period 6/9/14 through 8/7/14 with orders for skilled nurse services twice a week for the first 3 weeks and then once for the forth week and "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The clinical record evidenced the skilled nurse completed the comprehensive assessment on 6/9/14 and provided skilled nurse services and PT and OT evaluated the patient and provided services on 6/9/14. The plan of care failed to evidence specific physician orders for the therapy treatments and services to be provided and the therapy goals. On 6/30/14 at 6 PM, employee A indicated the initial physician order to evaluate for home health services was completed by admitting nurse or therapist and that the therapist does not call for specific therapy orders. He / she indicated that each therapist sends their plan of care to the physician for signature, separate of the medical plan of care.			

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	157593	A. BUILDING 00 B. WING	06/30/2014

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	5. Clinical record number 12, SOC 6/23/14, evidenced the home health aide provided services on 6/23/14 from 3 - 4 PM. The clinical record failed to evidence orders for the aides services provided. The record evidenced the PT requested a physician order on 6/24/14, "effective 6/23/14," for an order for home health aide services two times a week for 5 weeks. 6. Policy titled "Medical Plan Of Care" dated 3/27/14 stated, "Home care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on the comprehensive assessment and information provided by the client / family and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary. ... Purpose - To provide guidelines MCHS [Mulberry Community Health Services] staff to develop a plan of care individualized to meet specific identified needs. To reflect client's ability to make choices and actively participate in establishing and			

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	following the plan designated to attain personal health goals. ... An individualized Plan Of Care signed by a physician shall be required for each client receiving home health and personal care services. The plan of Care shall be completed in full to include: All pertinent diagnosis(es), ... c. Type, frequency, and duration of all visits / services. d. specific procedures and modalities for therapy services. e. diagnostic tests, including laboratory and x-rays. ... g. prognosis. h. Rehabilitation potential, ... l. ... treatments, and procedures, ... n. Any safety measures to protect against injury, o. Instructions to client / caregiver, as applicable, p. Treatment goals."			
G000162	484.18(a) PLAN OF CARE The therapist and other agency personnel participate in developing the plan of care. Based on clinical record review and interview, the agency failed to ensure all personnel providing care participated in the development of the patient's written plan of care in 4 (# 2, 5, 6, and 10) of 11 clinical records reviewed of patients receiving therapy services.	G000162	No correction from the provider can be done due to the time frame of the Plan of Care. Administrator and/or Clinical Supervisor will complete the in-service to all nursing, therapist and home health aide on Medical Plan of Care Policy and Procedure by 07.30.14. PT and OT evaluation dated 05.22.14	07/30/2014

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	The findings include: 1. Clinical record 2, start of care (SOC) 5/22/14 for the certification period 5/22/14 through 7/20/14 stated, "Physical therapy [PT] to evaluate and treat per PT POC [plan of care]. Occupational Therapy [OT] to evaluate and treat per OT POC ... Goals / Rehabilitation Potential / Discharge Plans. ... 3. Client's gait will improve as evidenced by 5 - 10 steps using a standards walker with minimum to moderate assistance X 1 [one time] thru 06282014. ... Standing tolerance for 5 minutes in preparation for gait training if appropriate. ... Client will be able to make 5 steps using standard walker with min - moderated assistance X 1." The plan of care was signed by the director of nursing and dated 5/22/14. The record evidenced the comprehensive assessment was completed on 5/22/14 by a physical therapist and included the description of three stasis ulcers and stated, "Will call Dr. [name] if he is agreeable for MIST therapy to facilitate wound closure" A. The record evidenced a communication written by employee C, a PT, dated 5/27/14 which indicated the physician caring for the patients wound was contacted regarding potential		and signed by MD as part of comprehensive plan of care for Clinical Record 2 & 5. It will be the responsibility of all clinicians who are doing a specific discipline assessment to report to the Clinician performing the OASIS through the specific discipline Assessment Summary Form and convey the result of the evaluation done to be included on the Plan of Care effective 07.01.14. Starting 07.01.14; Administrator or designee will do chart audits 100% of all SOC for 2 weeks; 50% for the next 2 weeks; 20% for 2 consecutive weeks until 100% compliance to ensure all personnel providing care participated in the development of the patient's written plan of care. It will be the responsibility of the Administrator or designee to continue to monitor through discussing patients status and plan of care during weekly meetings to ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	

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	treatment which could be provided by the physical therapist in the home. B. The record failed to evidence all disciplines providing care to the patient participated in the development of the plan of care. 2. Clinical record 5, start of care 4/24/14, included a medical plan of care with orders for skilled nurse once a week for 4 weeks and "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The POC was signed by the DON and dated 4/24/14. The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 4/24/14. The record failed to evidence all disciplines providing care to the patient participated in the development of the plan of care. 3. Clinical record 6, SOC 6/23/14, included a medical plan of care for the certification period 6/23/14 with orders for skilled nurse once a week for 4 weeks and "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 6/23/14. The record failed to evidence all			

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	disciplines providing care to the patient participated in the development of the plan of care. 4. Clinical record # 10, start of care 6/9/14, included a medical plan of care for the certification period 6/9/14 through 8/7/14 with orders for skilled nurse services twice a week for the first 3 weeks and then once for the forth week and PT and OT to evaluate and treat per their plans of care. The clinical record evidenced the skilled nurse completed the comprehensive assessment and provided skilled nurse services on 6/9/14 and submitted the written medical plan of care to the physician for signature. The PT and OT also evaluated the patient and provided services on 6/9/14 and independently wrote their disciplines plan of care on the corresponding evaluation documents and each submitted a plan of care separately to the physician for signature. The plans of care and clinical record failed to evidence the physical and occupational therapist participated in the patient's medical plan of care. 5. On 6/30/14 at 6 PM, employee A indicated the agency's process was to write on the medical plan of care to refer to the therapy plans of care.			

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G000170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on interview and review of clinical records and policy, the agency failed to ensure the nursing services were provided in accordance with a written plan of care 2 of 11 clinical records reviewed (4 and 6) with the potential to effect all patients receiving nursing services. Findings: 1. Clinical record 4, start of care (SOC) 3/5/14, included a plan of care for the certification period 5/4/14 to 7/2/14 with orders for skilled nurse two times a week for eight weeks, then once a week for the last week, and "draw labs per physician orders." A. Skilled nurse visit note dated 5/20/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. B. Skilled nurse visit note dated 6/9/14 evidenced a blood draw was attempted from the patient's right upper	G000170	No correction can be done due to the time frame for the incomplete lab draws order on 05.20.14; 06.09.14; 06.16.14 on Clinical record 4 showing on the Plan of Care. Administrator conducted counseling with RNs (employee A and D) on skilled nursing services following plan of care established by the physician and specificity of orders to be included on the Plan of Care on 07.01.14. No correction can be done due to the time frame for not including the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing for client 6 onthe Plan of Care. Administrator conducted counseling with RN (employee A and D) on skilled nursing services following plan of care established by the physician and specificity of orders on 07.01.14. Administrator and/or Clinical Supervisor will completethe in-service to all nurses, therapists and home health aides on following: Physician Orders Policy and Procedures of the Home Health agency by 07.30.14. Starting 07.01.14; Administrator or designee will do chart audits	07/30/2014

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	arm. The record failed to evidence an order for the laboratory draw. C. Skilled nurse visit note dated 6/16/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. D. On 6/30/14 at 4 PM, employee A indicated the order for the laboratory draws was dated 4/29/14 and the current plan of care did not specify the laboratory orders. 2. Clinical record 6, SOC 6/23/14, included a medical plan of care for the certification period 6/23/14 to 8/21/14 which included orders for skilled nurse once a week for 4 weeks for wound care with bacitracin ointment to be applied topically to left shin wound, cover with adherent dressing, wrap with krrlex and secure with tape daily. In addition, under DME and supplies was listed the medication calcium alginate silver and normal saline and the dressing mepilex foam border dressing was listed. The plan of care failed to evidence the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing. The record evidenced the skilled nrse provided wound care using		100% of all SOC for 2 weeks; 50% for the next 2 weeks; 20% for 2 consecutive weeks until 100% compliance to ensure the nursing services were provided in accordance with a written plan of care. It will be the responsibility of the Administrator or designee to continue to monitor through discussing patients status and plan ofcare during weekly meetings to ensure this deficiency is corrected and will not reoccur. Date of Compliance 07.30.14	

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	the calcium alginate silver and normal saline and the dressing mepilex foam border dressing A. On 6/30/14 at 1:20 PM, employee D indicated, when asked, she did not have a physician order to provide wound care as documented on the comprehensive assessment. She indicated she wrote a request to the physician for the wound care orders following the assessment and provision of care. She indicated the wound care provided on 6/23/14 as documented was from the patient's supplies of calcium alginate silver, normal saline, and the dressing mepilex foam border. She indicated the patient had used this for the similar wounds prior to to the stay in the extended care facility and, therefore, she used it also. B. A physician order dated 6/23/14 stated, "Wound care to LLE stasis ulcers ... apply silvadene topically to LLE [left lower extremity] -place silver alginate to open ulcers, cover with mepilex foam border dressing ... d/c bacitracin to LLE." 3. During a face to face interview on 6/26/14 at 2:30 PM, employee E, a registered nurse, indicated he / she completed comprehensive assessments			

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	and admitted patients for home health services. He / she indicated the attending physician was not contacted after completion of the comprehensive assessment and prior to the rendering of care unless there was a concern or question. Employee E indicated an admission summary was written and sent to the attending physician by the clinician that admitted the patient.			
G000235	484.48 CLINICAL RECORDS Based on clinical record review and interview, it was determined the agency failed to ensure clinical records were accurately dated for in 1 of 1 record reviewed of patients receiving home health aide only services creating the potential to affect all 9 patients of the agency receiving home health aide services (See G 236). The cumulative effect of this systemic problem resulted in the agency not meeting the requirements of the Condition of Participation 484.48. Clinical records.	G000235	Administrator conducted counseling with RN on supervisory visit and accuracy of the documentation, time and date it happened, and following plan of care established by the physician on 07.01.14. Administrator will complete the in-service on clinical recordsbeing accurately dated and timed. Administrator and/or designee to randomly audit 25 % of visit notes and timesheets per week for 2 weeks until 100% compliance to ensure clinical records were accurately dated for 4 consecutive weeks. It will be the responsibility of the Administrator or designees to monitor that these corrective actions are followed and ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	07/30/2014
G000236	484.48			

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	CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. Based on clinical record review and interview, the agency failed to ensure clinical records were accurately dated for in 1 of 1 record reviewed of patients receiving home health aide only services creating the potential to affect all 9 patients of the agency receiving home health aide services. (Patient 11) The findings include: 1. Clinical record 11, start of care 10/15/13, included a plan of care for the certification periods 4/13/14 through 6/12/14 and 6/12/14 through 8/10/14 with orders for aide services once a week throughout the certification periods. A. The record evidenced aide visit notes documented services were provided weekly as ordered. Each aide visit note was also signed by a registered nurse.	G000236	Administrator conducted counseling with RN on supervisory visit and accuracy of the documentation, time and date it happened, and following plan of care established by the physician on 07.01.14. Administrator will complete the in-service on clinical records being accurately dated and timed. Administrator and/or designee to randomly audit 25 % of visit notes and timesheets per week for 2 weeks until 100% compliance to ensure clinical records were accurately dated for 4 consecutive weeks. It will be the responsibility of the Administrator or designees to monitor that these corrective actions are followed and ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	07/30/2014

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	The aide visit note dated 5/19/14 indicated employee D supervised and observed the care provided by the aide from 10:30 AM to 11:30 AM. The supervisory note stated, "Supervised visit completed at this time. HHA following POC [plan of care]. No additional instructions given." 2. Clinical record 9 evidenced a comprehensive assessment dated 5/19/14 beginning at 11 AM and completed at 12:10 PM. This client's address is 21 miles from patient 11. 3. On 6/30/14 at 6 PM, Employee D indicated that the documentation of the supervision for the aide was in error for 5/19/14. When asked, employee D indicated it was not her practice to document the supervisory visits at the time they occur. She indicated she documents the supervisory visits after the aide visit note arrives in the office and is reviewed. She indicated she does not know the exact date the onsite supervisory visits were completed.			
G000332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on clinical record and policy	G000332	All staff educated on Client Admission Process Policy and	07/30/2014

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	review and interview, the agency failed to ensure the registered nurse made an initial assessment visit within 48 hours of referral in 3 of 12 clinical records reviewed with the potential to affect all new patients. (# 3, 11, and 12) The findings include: 1. Clinical record 3, start of care 6/2/14, evidenced a referral dated 5/27/14 to evaluate for home services. The record evidenced a comprehensive assessment dated 6/2/14 and failed to evidence an initial assessment was completed within 48 hours of the verbal order for evaluation for home health services nor documentation to explain why the initial visit was late. 2. Clinical record 11, start of care 10/15/13, evidenced a referral dated 10/7/13 to evaluate for home services. The record evidenced a comprehensive assessment dated 10/11/13 and the first aide visit was made on 10/15/13. The record failed to evidence an initial assessment was completed within 48 hours of the verbal order for evaluation for home health services nor documentation to explain why the initial visit was late. 3. Clinical record 12, start of care		Procedures to ensure that timeliness of the initial assessment will be completed within 48 hrs of referral or within 48 hours of the clients return home, or on the Physician ordered start of care date on 07.01.14. Starting 07.01.14; Administrator or designee will audit 50% of admissions for 2 weeks; 25% for the succeeding 2 weeks until 2 consecutive weeks of 100% compliance to ensure the clinician performing assessment made an initial assessment visit within 48 hrs. It will be the responsibility of the Administrator or designees to monitor that these corrective actions are followed and ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	

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	6/23/14, evidenced a written referral from the attending physician to evaluate for home services and faxed to the agency on 6/18/14. The record evidenced a comprehensive assessment dated 6/23/14 that indicated the referral was received on 6/18/14. The record failed to evidence an initial assessment was completed within 48 hours of the verbal order for evaluation for home health services nor documentation to explain why the initial visit was late. 4. The policy titled "Client Admission Process" dated 3/27/14 stated, "The Initial Assessment will be completed within 48 hours of referral or within 48 hours the clients return home, or on the Physician ordered start of care date."			
N000000	This was a home health agency relicensure survey. Survey Dates: June 24, 25, 26, 27, and 30, 2014 Facility #: 010480	N000000	Submission of this plan of correction and credibleallegation of compliance does not constitute an admission by the certified andlicensed provider at Mulberry Community Health Services that the allegationscontained in the survey report are true and accurate portrayal of theprovisions of nursing care and other services at this healthcare	

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	Medicaid Vendor #: 200863280 Surveyor: Bridget Boston, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN July 7, 2014		agency. The agency recognizes its obligation toprovide legally and medically required services to its patients in an economicand efficient fashion. The agency herebymaintains that it is in substantial compliance with Federal participatingrequirements for home health agency participating in the Medicareprograms. As a result, this plan ofcorrection constitutes an allegation of compliance of Federal and Stateregulations. Mulberry Community Health Services respectfully requests a Desk Review in lieu of a Post Survey revisit on or after July 30, 2014.	
N000522	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on interview and review of clinical records and policy, the agency failed to ensure the medical care provided to the patient followed the medical plan of care as established by the physician and the attending physician was consulted and orders were obtained prior to the provision of skilled care in 5 of 11 current clinical records reviewed with the potential to affect all current 28 patients. (4, 6, 7, 9, and 10)	N000522	No correction can be done due to the time frame for the incomplete lab draws order on 05.20.14; 06.09.14; 06.16.14 on Clinical record 4 showing on the Plan of Care. Administrator conducted counseling with RN (employee A and D) and PT/OTon following plan of care established by the physician, and specificity oforders to be included on the Plan of Care on 07.01.14. No correction can be done due to the time frame for not including the specific location of treatment for	07/30/2014

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	157593	A. BUILDING 00 B. WING	06/30/2014

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	Findings: 1. Clinical record 4, start of care (SOC) 3/5/14, included a plan of care for the certification period 5/4/14 to 7/2/14 with orders for skilled nurse two times a week for eight weeks, then once a week for the last week and "draw labs per physician orders." A. Skilled nurse visit note dated 5/20/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. B. Skilled nurse visit note dated 6/9/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. C. Skilled nurse visit note dated 6/16/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. D. On 6/30/14 at 4 PM, employee A indicated the order for the laboratory draws was dated 4/29/14 and the current plan of care did not specify the laboratory orders.		the calcium alginate silver and normal saline and the dressing mepilex foam border dressing for client 6 onthe Plan of Care. Administrator conducted counseling with RN (employee A and D) and PT/OT on following plan of care established by the physician, specificity of orders, and obtaining orders prior to proceeding with specific treatment on 07.01.14. It will be the responsibility of all clinicians who are doing a specific discipline assessment to report to the Clinician performing the OASIS through the specific discipline Assessment Summary Form and convey the result of the evaluation done to be included on the Plan of Care effective 07.01.14. Administrator and/or Clinical Supervisor will complete the in-service to all nurses, therapists and home health aides on following: Medical Plan of Care Policy and Procedures of the Home Health agency by 07.30.14. Starting 07.01.14; Administrator or designee will do chart audits on 100% of all SOC for 2 weeks; 50% for the next 2 weeks; 20% for the succeeding 2 weeks until 2 consecutive weeks of 100% compliance to ensure that Medical Plan of Care established by Physician & Attending Physician was consulted, and orders were obtained prior to the provision of skilled care. It will be the responsibility of the Administrator	

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	2. Clinical record 6, SOC 6/23/14, included a medical plan of care for the certification period 6/23/14 to 8/21/14 with orders for skilled nurse once a week for 4 weeks for wound care with bacitracin ointment to be applied topically to left shin wound, cover with adherent dressing, wrap with kerlex and secure with tape daily. In addition, under DME (durable medical equipment) and supplies were listed the medication calcium alginate silver and normal saline and the dressing mepilex foam border dressing. The plan of care failed to evidence the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing. A. On 6/30/14 at 1:20 PM, employee D indicated, when asked, she did not have a physician order to provide wound care as documented on the comprehensive assessment. She indicated she wrote a request to the physician for the wound care orders following the assessment and provision of care. She indicated the wound care provided on 6/23/14 as documented was from the patient's supplies of calcium alginate silver, normal saline, and the dressing mepilex foam border. She indicated the patient had used these for		or designee to continue to monitor through discussing patients status and plan of care during weekly meetings to ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	

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	the similar wounds prior to to the stay in the extended care facility and, therefore, she provided wound care with the same medications and then sent a request to the physician to change the treatment orders. A physician order dated 6/23/14 stated, "Wound care to LLE stasis ulcers ... apply silvadene topically to LLE [left lower extremity] - place silver alginate to open ulcers, cover with mepilex foam border dressing ... d/c [discontinue] bacitracin to LLE." B. The plan of care for the certification period beginning 6/23/14 had orders that stated, "Physical Therapy [physical therapy] to evaluate and treat per PT POC [plan of care] and Occupational Therapy [OT] to evaluate and treat per OT POC." The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 6/23/14. The POC failed to evidence the OT and PT treatments and services to be provided and the patient's therapy related goals. 3. Clinical record 7, SOC 5/19/14, evidenced a medical plan of care for the certification period 5/19/14 through 7/17/14 with orders for PT twice a week for four weeks. The record evidenced OT evaluated and began providing			

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	services on 5/20/14. OT services were provided on 5/22/14 and 5/26/14. The record failed to evidence orders from the attending physician were received for OT services until 5/27/14. 4. Clinical record 9, SOC 5/19/14, included a plan of care for the certification period 5/19/14 to 7/17/14 with orders for skilled nurse twice a week for the first 4 weeks and then three times a week for the next 3 weeks of the certification period. The clinical record failed to evidence three skilled nurse visits were made as ordered during week five of the certification period. Documentation evidenced skilled nurse visits were made on June 10 and 12 during week four, on June 17 during week five, and June 24 during week six, and the patient was discharged from skilled nurse services on 6/24/14. 5. Clinical record # 10, start of care 6/9/14, included a medical plan of care for the certification period 6/9/14 through 8/7/14 with orders for skilled nurse services twice a week for the first 3 weeks and then once for the forth week and PT and OT to evaluate and treat per their plans of care. A. The clinical record evidenced the PT and OT evaluated on 6/9/14 and each			

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	discipline provided the first therapy treatment at the time of the evaluation. The clinical record failed to evidence specific verbal or written physician orders, prior to the provision of care, for the treatments and services provided on 6/9/14. B. A communication document dated 6/9/14 written by employee A indicated the patient was evaluated for PT services admitted for PT services. C. A communication document dated 6/9/14 written by employee B to the attending physician, indicated the patient was evaluated and admitted for OT services on 6/9/14. The communication was written on 6/10/14. D. On 6/30/14 at 1 PM, employee A indicated the disciplines do not call the attending prior to the provision of care. He indicated the "admit and treat for services as indicated" was the agency's order to treat patients. E. Review of the policy titled "Physician Orders" approval date 3/27/14, states, "All treatment and care must be ordered, dated, and signed by the physician ... The orders may be initiated by telephone or in writing ... 6. A copy of the order must be placed in the chart until			

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	the original is signed ... All physician orders shall be maintained in the clinical record." 6. On 6/30/14 at 3:06 PM, employee A indicated there was no other documentation to evidence.			
N000524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment.			

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	(xiii) Any other appropriate items. Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all medications, treatments, and services in 5 of 11 current records reviewed creating the potential to affect all 28 patients receiving services within the agency. (# 2, 5, 6, 10, and 12) Findings include: 1. Clinical record 2, start of care (SOC) 5/22/14, included a plan of care for the certification period 5/22/14 through 7/20/14 that stated, "Physical therapy [PT] to evaluate and treat per PT POC [plan of care]. Occupational Therapy [OT] to evaluate and treat per OT POC ... Goals / Rehabilitation Potential / Discharge Plans. ... 3. Client's gait will improve as evidenced by 5 - 10 steps using a standards walker with minimum to moderate assistance X 1 [one time] thru 06282014. ... Standing tolerance for 5 minutes in preparation for gait training if appropriate. ... Client will be able to make 5 steps using standard walker with min - moderated assistance X 1." A. The record evidenced the comprehensive assessment was completed by a physical therapist and included the description of three stasis	N000524	Administrator conducted counseling with PT and OT on ensuring plans of care includes all medication, treatments, and services on 07.01.14. PT and OT evaluation dated 05.22.14 and signed by MD as part of comprehensive plan of care for Clinical Record 2. PT and OT evaluation dated 06.09.14 and signed by MD as part of comprehensive plan of care for Clinical Record 10. No correction can be done due to the time frame for not including the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing for client 6 onthe Plan of Care. Administrator conducted counseling with RN (employee A and D) and PT/OT on following plan of care established by the physician, and specificity of orders on 07.01.14. It will be the responsibility of all clinicians who are doing a specific discipline assessment to report to the Clinician performing the OASIS through the specific discipline Assessment Summary Form and convey the result of the evaluation done to be included on the Plan of Care effective 07.01.14. Administrator or designee will do chart audits 100% of all SOC for 2 weeks; 50% for the next 2 weeks; 20% for the succeeding 2 weeks until 2 consecutive weeks of 100%	07/30/2014

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	ulcers and stated, "Will call Dr. [name] if he is agreeable for MIST therapy to facilitate wound closer." The POC failed to evidence the patient had wounds, the treatment orders, and who was caring for them. B. The record evidenced the OT evaluated the patient on 5/22/14. The plan of care failed to evidence the treatments and services to be provided by the occupational therapist and the patients goals as related to OT. C. During a home visit on 6/25/14 at 8:30 AM, the patient was observed to be wheelchair bound. The caregiver and patient were interviewed and indicated the patient was transferred between surfaces with maximum assistance of one individual that is capable of weight bearing assistance; the patient was not capable of transferring self, not standing, or ambulation. 2. Clinical record 5, start of care 4/24/14, included a medical plan of care with orders for skilled nurse once a week for 4 weeks, and "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 4/24/14.		compliance following plans of care included all medications, treatments, and services starting 07.01.14. Administrator and/or Clinical Supervisor will completethe in-service to all nurses, therapists, and home health aides on the following: Medical Plan of Care Policy and Procedure by 07.30.14. It will be the responsibility of the Administrator or designee to continue to monitor through discussing patients status and plan of care during weekly meetings to ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	

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	The POC failed to evidence the OT and PT treatments, services to be provided, and the patient's goals. 3. Clinical record 6, SOC 6/23/14, included a medical plan of care for the certification period 6/23/14 which included orders for skilled nurse once a week for 4 weeks for wound care. The plan of care was not clear what the treatment order was to be for the wounds on the left shin areas. The plan of care included orders for bacitracin ointment to be applied topically to left shin wound, cover with adherent dressing, wrap with kerlex, and secure with tape daily. In addition, under DME (durable medical equipment) and supplies, the medication calcium alginate silver and normal saline and the dressing mepilex foam border dressing was listed. The plan of care failed to evidence the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing. A. The plan of care for the certification period 6/23/14 with orders that stated, "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 6/23/14.			

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	The POC failed to evidence the OT and PT treatments, services to be provided, and the patient's related therapy goals. B. The plan of care included orders for Humalog Insulin per sliding scale and bacitracin ointment to the left shin areas. The physician order dated 6/23/14 discontinued the insulin due to the patient did not use the insulin and discontinued the bacitracin ointment. 4. Clinical record # 10, start of care 6/9/14, included a medical plan of care for the certification period 6/9/14 through 8/7/14 with orders for skilled nurse services twice a week for the first 3 weeks and then once for the forth week and "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The clinical record evidenced the skilled nurse completed the comprehensive assessment on 6/9/14 and provided skilled nurse services and PT and OT evaluated the patient and provided services on 6/9/14. The plan of care failed to evidence specific physician orders for the therapy treatments and services to be provided and the therapy goals. 5. Clinical record number 12, SOC 6/23/14, evidenced the home health aide			

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	provided services on 6/23/14 from 3 - 4 PM. The clinical record failed to evidence orders for the aides services provided. The record evidenced the PT requested a physician order on 6/24/14, "effective 6/23/14," for an order for home health aide services two times a week for 5 weeks. 6. Policy titled "Medical Plan Of Care" dated 3/27/14 stated, "Home care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on the comprehensive assessment and information provided by the client / family and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary. ... Purpose - To provide guidelines MCHS [Mulberry Community Health Services] staff to develop a plan of care individualized to meet specific identified needs. To reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals. ... An individualized Plan Of Care signed by a			

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	physician shall be required for each client receiving home health and personal care services. The plan of Care shall be completed in full to include: All pertinent diagnosis(es), ... c. Type, frequency, and duration of all visits / services. d. specific procedures and modalities for therapy services. e. diagnostic tests, including laboratory and x-rays. ... g. prognosis. h. Rehabilitation potential, ... l. ... treatments, and procedures, ... n. Any safety measures to protect against injury, o. Instructions to client / caregiver, as applicable, p. Treatment goals."			
N000537	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 interview and review of clinical records and policy, the agency failed to ensure the nursing services were provided in accordance with a written plan of care 2 of 11 clinical records reviewed (4 and 6) with the potential to effect all patients receiving nursing services. Findings:	N000537	No correction can be done due to the time frame for the incomplete lab draws order on 05.20.14; 06.09.14; 06.16.14 on Clinical record 4 showing on the Plan of Care. Administrator conducted counseling with RNs (employee A and D) on skilled nursing services following plan of care established by the physician, and specificity of orders to be included on the Plan	07/30/2014

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	1. Clinical record 4, start of care (SOC) 3/5/14, included a plan of care for the certification period 5/4/14 to 7/2/14 with orders for skilled nurse two times a week for eight weeks, then once a week for the last week, and "draw labs per physician orders." A. Skilled nurse visit note dated 5/20/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. B. Skilled nurse visit note dated 6/9/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. C. Skilled nurse visit note dated 6/16/14 evidenced a blood draw was attempted from the patient's right upper arm. The record failed to evidence an order for the laboratory draw. D. On 6/30/14 at 4 PM, employee A indicated the order for the laboratory draws was dated 4/29/14 and the current plan of care did not specify the laboratory orders. 2. Clinical record 6, SOC 6/23/14,		of Care on 07.01.14. No correction can be done due to the time frame for not including the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing for client 6 onthe Plan of Care. Administrator conducted counseling with RN (employee A and D) on skilled nursing services following plan of care established by the physician and specificity of orders on 07.01.14. Administrator and/or Clinical Supervisor will complete the in-service to all nurses, therapists, and home health aides on following Medical Plan of Care, and Physician Orders Policy and Procedures of the Home Health agency by 07.30.14. Starting 07.01.14; Administrator or designee will do chart audits on 100% of all SOC for 2 weeks; 50% for the next 2 weeks; 20% for the succeeding 2 weeks until 2 consecutive weeks of 100% compliance to ensure the nursing services were provided in accordance with a written plan of care. It will be the responsibility of the Administrator or designee to continue to monitor through discussing patients status and plan ofcare during weekly meetings to ensure this deficiency is corrected and will not reoccur. Date of Compliance 07.30.14	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY COMMUNITY HEALTH SERVICES	502 W JACKSON ST MULBERRY, IN 46058

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	included a medical plan of care for the certification period 6/23/14 to 8/21/14 which included orders for skilled nurse once a week for 4 weeks for wound care with bacitracin ointment to be applied topically to left shin wound, cover with adherent dressing, wrap with krrlex and secure with tape daily. In addition, under DME and supplies was listed the medication calcium alginate silver and normal saline and the dressing mepilex foam border dressing was listed. The plan of care failed to evidence the specific location of treatment for the calcium alginate silver and normal saline and the dressing mepilex foam border dressing. The record evidenced the skilled nrse provided wound care using the calcium alginate silver and normal saline and the dressing mepilex foam border dressing A. On 6/30/14 at 1:20 PM, employee D indicated, when asked, she did not have a physician order to provide wound care as documented on the comprehensive assessment. She indicated she wrote a request to the physician for the wound care orders following the assessment and provision of care. She indicated the wound care provided on 6/23/14 as documented was from the patient's supplies of calcium alginate silver, normal saline, and the			

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	dressing mepilex foam border. She indicated the patient had used this for the similar wounds prior to to the stay in the extended care facility and, therefore, she used it also. B. A physician order dated 6/23/14 stated, "Wound care to LLE stasis ulcers ... apply silvadene topically to LLE [left lower extremity] -place silver alginate to open ulcers, cover with mepilex foam border dressing ... d/c bacitracin to LLE." 3. During a face to face interview on 6/26/14 at 2:30 PM, employee E, a registered nurse, indicated he / she completed comprehensive assessments and admitted patients for home health services. He / she indicated the attending physician was not contacted after completion of the comprehensive assessment and prior to the rendering of care unless there was a concern or question. Employee E indicated an admission summary was written and sent to the attending physician by the clinician that admitted the patient.			
N000565	410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary);			

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	Based on clinical record review and interview, the agency failed to ensure the therapist providing care participated in the development of the patient's written plan of care in 4 (# 2, 5, 6, and 10) of 11 clinical records reviewed of patients receiving therapy services. The findings include: 1. Clinical record 2, start of care (SOC) 5/22/14 for the certification period 5/22/14 through 7/20/14 stated, "Physical therapy [PT] to evaluate and treat per PT POC [plan of care]. Occupational Therapy [OT] to evaluate and treat per OT POC ... Goals / Rehabilitation Potential / Discharge Plans. ... 3. Client's gait will improve as evidenced by 5 - 10 steps using a standards walker with minimum to moderate assistance X 1 [one time] thru 06282014. ... Standing tolerance for 5 minutes in preparation for gait training if appropriate. ... Client will be able to make 5 steps using standard walker with min - moderated assistance X 1." The plan of care was signed by the director of nursing and dated 5/22/14. The record evidenced the comprehensive assessment was completed on 5/22/14 by a physical therapist and included the description of three stasis ulcers and stated, "Will call Dr. [name] if he is agreeable for MIST therapy to facilitate	N000565	It will be the responsibility of all clinicians who are doing a specific discipline assessment to report to the Clinician performing the OASIS through the specific discipline Assessment Summary Form, and convey the result of the evaluation done to be included on the Plan of Care effective07.01.14. Administrator conducted counseling with PT and OT on ensuring plans of care includes all medication, treatments, and services on 07.01.14. Starting 07.01.14; Administrator or designee will do chart audits on 100% of all SOC for 2 weeks; 50% for the next 2 weeks; 20% for the succeeding 2 weeks until 2 consecutive weeks of 100% compliance to ensurethe therapist providing care participated in the development of the patient's written plan of care. Administrator and/or Clinical Supervisor will complete the in-service to all nurses, therapists and home health aides on following: Medical Plan of Care and Physician Orders Policy and Procedures of the Home Health agency by 07.30.14. It will be the responsibility of the Administrator or designee to continue to monitor through discussing patients status and plan of care during weekly meetings to ensure this deficiency is corrected and will not reoccur. Date of Compliance 07.30.14	07/30/2014

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	wound closure" A. The record evidenced a communication written by employee C, a PT, dated 5/27/14 which indicated the physician caring for the patients wound was contacted regarding potential treatment which could be provided by the physical therapist in the home. B. The record failed to evidence all disciplines providing care to the patient participated in the development of the plan of care. 2. Clinical record 5, start of care 4/24/14, included a medical plan of care with orders for skilled nurse once a week for 4 weeks and "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The POC was signed by the DON and dated 4/24/14. The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 4/24/14. The record failed to evidence all disciplines providing care to the patient participated in the development of the plan of care. 3. Clinical record 6, SOC 6/23/14, included a medical plan of care for the certification period 6/23/14 with orders for skilled nurse once a week for 4 weeks			

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	and "Physical Therapy to evaluate and treat per PT POC and Occupational Therapy to evaluate and treat per OT POC." The record evidenced the skilled nurse, OT, and PT all evaluated and began providing services on 6/23/14. The record failed to evidence all disciplines providing care to the patient participated in the development of the plan of care. 4. Clinical record # 10, start of care 6/9/14, included a medical plan of care for the certification period 6/9/14 through 8/7/14 with orders for skilled nurse services twice a week for the first 3 weeks and then once for the forth week and PT and OT to evaluate and treat per their plans of care. The clinical record evidenced the skilled nurse completed the comprehensive assessment and provided skilled nurse services on 6/9/14 and submitted the written medical plan of care to the physician for signature. The PT and OT also evaluated the patient and provided services on 6/9/14 and independently wrote their disciplines plan of care on the corresponding evaluation documents and each submitted a plan of care separately to the physician for signature. The plans of care and clinical record failed to evidence the physical and			

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	occupational therapist participated in the patient's medical plan of care. 5. On 6/30/14 at 6 PM, employee A indicated the agency's process was to write on the medical plan of care to refer to the therapy plans of care.			
N000606	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on clinical record review and interview, the agency failed to ensure the registered nurse made an on-site visit to the patient's home no less frequently than every 30 days in 1 of 1 record reviewed of patients receiving home health aide only services creating the potential to affect all 9 patients of the agency receiving home health aide services. (Patient 11) The findings include: 1. Clinical record 11, start of care 10/15/13, included a plan of care for the certification periods 4/13/14 through 6/12/14 and 6/12/14 through 8/10/14 with orders for aide services once a week	N000606	Administrator conducted counseling with RN on supervisory visit, accuracy of the documentation, time and date it happened, and following plan of care established by the physician on 07.01.14. Administrator or designee to audit 50% of clients with HHA for 2 weeks and 25% in the succeeding 4 weeks until 100% compliant of supervisory visits starting 07.01.14. Scheduler created a tracker Visits for all clients to monitor number of visits, and scheduled supervisory visits based on the Federal and State regulations. Administrator will complete the in-service on clinical records to ensure they are accurately dated, timed and include a time frame for the supervisory visit based on the Federal and State regulations	07/30/2014

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	throughout the certification periods. On 6/26/14 at 12 PM, employee A indicated the patient was discharged on 6/23/14 and admitted for skilled services. A. During the entrance conference, employee D indicated documentation of the supervisory visits would be found on the aide visit note. B. The record evidenced aide visit notes documented services were provided weekly as ordered. Each aide visit note was also signed by a registered nurse. The aide visit note dated 5/19/14 indicated employee D supervised and observed the care provided by the aide from 10:30 AM to 11:30 AM. The supervisory note stated, "Supervised visit completed at this time. HHA following POC [plan of care]. No additional instructions given." C. Clinical record 9 evidenced a comprehensive assessment dated 5/19/14 beginning at 11 AM and completed at 12:10 PM. This client's address is 21 miles from patient 11. D. On 6/30/14 at 6 PM, employee A and D indicated they were both at the home at patient 9 on 5/19/14, at the same time. They indicated employee D completed the comprehensive		by 07.30.14. It will be the responsibility of the Administrator or designees to monitor that these corrective actions are followed and ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	

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	assessment and employee A completed the PT evaluation following completion of the comprehensive assessment. Employee D indicated that the documentation of the supervision for the aide was in error for 5/19/14. When asked, employee D indicated it was not her practice to document the supervisory visits at the time they occur. She indicated she documents the supervisory visits after the aide visit note arrives in the office and is reviewed. She indicated she does not know the exact date the onsite supervisory visits were completed. 2. On 6/26/14 at 1:30 PM, during a home visit observation with patient 12 (closed patient 11). The patient and the primary caregiver indicated employee D arrived to the home while the patient was receiving aide only services every 6 - 8 weeks and the aide was not always present during those visits.			
N000608	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.			

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	(3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on clinical record review and interview, the agency failed to ensure clinical records were accurately dated for in 1 of 1 record reviewed of patients receiving home health aide only services creating the potential to affect all 9 patients of the agency receiving home health aide services. (Patient 11) The findings include: 1. Clinical record 11, start of care 10/15/13, included a plan of care for the certification periods 4/13/14 through 6/12/14 and 6/12/14 through 8/10/14 with orders for aide services once a week throughout the certification periods. A. The record evidenced aide visit notes documented services were provided weekly as ordered. Each aide visit note was also signed by a registered nurse. The aide visit note dated 5/19/14 indicated employee D supervised and observed the care provided by the aide	N000608	Administrator conducted counseling with RN on supervisory visit, accuracy of the documentation, time and date it happened, and following plan of care established by the physician on 07.01.14. Administrator will complete the in-service to all staff on clinical records being accurately dated and timed by 07.30.14. Administrator and/or designee to randomly audit 25 % of visit notes to compare it to the corresponding timesheets per week for 2 weeks until 100% accurate for 4 consecutive weeks starting 07.01.14. It will be the responsibility of the Administrator or designees to monitor that these corrective actions are followed and ensure this deficiency is corrected and will not reoccur. Date of Compliance: 07.30.14	07/30/2014

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	from 10:30 AM to 11:30 AM. The supervisory note stated, "Supervised visit completed at this time. HHA following POC [plan of care]. No additional instructions given." 2. Clinical record 9 evidenced a comprehensive assessment dated 5/19/14 beginning at 11 AM and completed at 12:10 PM. This client's address is 21 miles from patient 11. 3. On 6/30/14 at 6 PM, Employee D indicated that the documentation of the supervision for the aide was in error for 5/19/14. When asked, employee D indicated it was not her practice to document the supervisory visits at the time they occur. She indicated she documents the supervisory visits after the aide visit note arrives in the office and is reviewed. She indicated she does not know the exact date the onsite supervisory visits were completed.			