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	157631	A. BUILDING 00 B. WING	06/13/2014

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COMFORT HOME HEALTH LLC	1815 S PLATE STREET KOKOMO, IN 46902

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G000121	484.12(c) COMPLIANCE W/ ACCEPTED 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 review of documents, the agency failed to ensure the home health aide (HHA) followed standard infection control practices for 2 of 3 (2 and 3) home health aide visits observed resulting in the potential for patient harm and the potential to affect all current 90 patients receiving home health aide services. (Employees D and E) Findings: 1. On 6/12/14 at 9:30 AM, a bed bath was observed in the home of patient 2 performed by home health aide D. The patient lives in a private residence and has a single hospital bed located in the living room. The patient is morbidly obese but is capable of moving from side to side and rolling over. The HHA used two pans to get water and washcloths from the bathroom. The patient participated with washing the face, arms, and torso. The HHA changed the water but did not change out the washcloths. The HHA washed the back and then got one new washcloth. The HHA washed the inner genital area twice going front to	G000121	All aides will be re-inserviced on proper procedure for bed bath. The agency will ensure all aides comply with professional standards of care. The agency will evaluate staff compliance through weekly random supervisory visits. Aides observed not following standards of practice for bed baths will have to go through re-training before they are allowed to continue to provide care in the pt's home environment. The DON and ADON are responsible for ensuring on-going compliance with this requirement. The agency will ensure staff follows standard infection control practices. The deficiency will be corrected by July 13, 14.	07/13/2014

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

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	back, and then the outer area of the genital area and then came back to the inner area and went front to back using the one clean washcloth. The HHA then used the second washcloth from the second tub which was the dirty washcloths to rinse starting on the inside and repeating the process. 2. On 6/12/14 at 11:30 AM, a bed bath was observed in the home of patient 3 performed by HHA E. The patient lives in a private residence and has a single hospital bed located in the living room. The patient is totally dependent for care. The HHA washed the face, arms and torso. The HHA changed the water, then washed the legs, back, the buttocks, and the peri area. The HHA washed from front to back and then back to front. The HHA rinsed the same. 3. The Alternate Director of Nursing, Employee F escorted the surveyor on all home visits and observed all care. 4. The website http://www.nursingassistanteducation.com identifies how to give a bed bath and includes instructions on performing perineal care for men and women who do not have a perineal catheter. The instructions state, "Fill the bath basin with clean water at 110 degrees ... and			

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	wash, rinse and dry the rectal area." The instructions include specific instructions on how to wash the perineal area before the rectal area which is different for men and women.			
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 provision of skilled care, and documented for all skilled care, services, and treatments to be provided in 7 of 12 clinical records reviewed (1, 2, 5, 9, 10, 11, and 12) with the potential to effect all current 150 patients. Findings: 1. On 6/11/14 at 1:20 PM, a co-owner, Employee S, indicated the agency used at least two software programs for the electronic health records, one specifically	G000158	G158/N522- The agency will ensure that all active patient charts will be reviewed by DON, ADON or QI Manager for MD notification of POC by SN and/or therapists. If the review shows the MD was not contacted by being documented on page 1 of the disciplines careplan, then the MD will be contacted by phone by 7-11-14 and a clarification order will be written that the MD was contacted regarding the development of the POC. This will be monitored ongoing on every new admit and recert by the DON and/or ADON with review of paperwork as it is turned in. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of	07/13/2014

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	for medicare patients, and one specifically for medicaid patients, and indicated the surveyors would not be granted a read only access to the electronic clinical records; access would be through the staff. 2. Clinical record 12, start of care 5/19/14, failed to evidence a plan of care signed by the physician at the time of the survey on 6/13/14. A verbal order was obtained 5/19/14 for Home care evaluation and treat skilled nurse 2 times a week times 1 week, physical therapy evaluation and treat and occupational therapy evaluation and treat. The physician signed the verbal order 5/27/14. A. The physical therapy evaluation was performed 5/24/14 with requested visits 1 times week times 1 week, 2 times week times 4 weeks, then 1 time for 1 week. The physical therapy form did not indicate the physician had been notified and the physician had not signed the physical therapy order for visits. B. The occupation therapy evaluation was performed 5/20/14 with requested visits 2 times week times 2 weeks and 1 times a week times 3 weeks. The occupational therapy form did not indicate the physician had been notified		care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	

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	and the physician had not signed the occupational therapy order for visits. C. The clinical record evidenced skilled nurse visits without orders week 3 on 5/29/14 and week 4 on 6/2/14; physical therapy visits without orders week 3 on 5/28/14 and 5/30/14 and week 4 on 6/3/14 and 6/5/14; and occupational therapy visits without orders week 3 on 5/27/14 and 5/29/14 and week 4 on 6/3/14. 3. The undated policy titled "Physician's Plan Of Treatment" number 2.18, stated, "A physician authorizes a plan of treatment prepared by the agency. Admission orders will be obtained prior to evaluation and treatment of the patient. ... Verbal orders may be accepted by professional nursing staff from a physician or staff nurse. They must be signed and dated within thirty (30) days. Verbal orders are to be recorded in the patient's clinical record by the professional receiving them. ... A physicians plan of care ... must include: The type and frequency of services needed, medications, specific orders for frequency or visits. ... Any changes to the physician's plan of treatment shall be reviewed by the attending physician."			

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	4. The undated policy titled "Medication Administration Guidelines" number 2.57 stated, "Antibiotics a. Nurses are only permitted to give the initial dose in the home with knowledge of the physician and specific orders for treatment of a reaction are provided by the physician. ... The nurse should observe the patient / client for any reaction for at least 30 minutes after the dose is given. ... Document medication administration by charting it in the patient / client's clinical record, to include: a. medication name, dose, route, ... c. medication date and time. ... Observe the patient / client for medication results and document, ... 1. Verify the physician order for medication administration. 2. Verify the date and time of the last medication administration by checking the documentation in the patient / client record." 5. Clinical record 1, start of care (SOC) evidenced a plan of care for the certification period 5/23/14 through 6/11/14 with orders for skilled nurse once a week for eight weeks, physical therapy to evaluate and treat, and occupational therapy to evaluate and treat by the second week. Employee B signed the plan of care and dated 5/21/14 indicating a verbal order was received for these orders on 5/21/14. The record failed to evidence the verbal order referenced.			

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	A. The record included a two page referral dated 5/21/14 which was signed by employee B. The referral did not include a verbal order as written on the plan of care. B. A physician order dated 5/23/14, written by employee K, indicated a verbal order was obtained from the attending physician for home health care evaluate and treat, skilled nurse one visit during week one, and physical therapy and occupational therapy to evaluate and treat the week of May 25, 2014 . C. The record evidenced the occupational therapist completed an assessment on 5/31/14 and completed additional visits on June 2 and June 4, 2014. The record failed to evidence a physicians order for the occupational visits and the services provided. 6. Clinical record # 2, SOC 2/21/14, included a physician order dated 4/17/14 at 3 PM that indicated the order was for the recertification for Home Health Care. Skilled nursing was ordered once a week for 9 weeks, aide services were to be provided twice a week for nine weeks, and occupational and physical therapy were to evaluate and treat.			

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	A. The record included a medical plan of care for the certification period 4/22/14 through 6/20/14 with orders for the skilled nurse services once a week for nine weeks, aide services twice a week for nine weeks, physical therapy services twice a week for four weeks then once a week for two weeks, and occupational therapy once a week for two weeks, twice a week for two weeks, and once a week for two weeks. B. The record evidenced the physical therapist reassessed the patient on 4/15/14, seven days prior to the start of the certification period. The record failed to evidence an assessment by physical therapy occurred on or after the date of the physician order to assess dated 4/17/14. The record failed to evidence two visits were made during week four of the certification period. The record indicated one visit was made on May 14, 2014. C. The record failed to evidence any aide visits / services were provided during week one of the certification period. D. The record failed to evidence the occupation therapy services were provided as ordered. There were no			

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	occupational visits made during week one. 7. Clinical record 5, start of care 4/16/14, included a medical plan of care for the certification period 4/16/14 through 6/16/14 with orders for skilled nursing to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a week for 7 weeks to assess / evaluate all body systems, wound care - right inner buttock, cleanse with normal saline, apply alginate and cover with mepilex daily, and wound care - left inner buttock - cleanse with normal saline, apply black sponge and wound vacuum at 125 mmHg, change every 3 days. The plan of care included an IV medication order for zosyn 2.25 milligrams to be administered every 8 hours for six days. The record included a physician order dated 4/16/14 for home health evaluate and treat, written by employee K at 4:30 PM. The record failed to evidence a physician was consulted for wound treatment orders and the IV antibiotic orders as written on the plan of care. A. The record included a comprehensive assessment dated 4/16/14, completed by employee K, that indicated the visit occurred between 7:15 PM and 9:15 PM, included the diagnoses of necrotizing fasciitis and acute renal			

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	failure. The patient had been discharged from the hospital the same day, 4/16/14, assessed to have a peripherally inserted central catheter [PICC] line inserted on 4/9/14 at the left antecubital space, no arm circumference or the length of the tubing exposed was documented, and lack of knowledge related to medication administration was identified and documented. Post operative surgical debridement of wounds during the hospitalization - wound description on the left inner buttock / perineum was 16.5 centimeters (cm) width X 3.3 cm length X 1.8 cm depth, 20 percent eschar and 80 % granulating tissue and the wound on the right inner buttock was 2.4 cm width 0.6 cm length X 0.4 cm depth 15 % slough / eschar and 85 % granulating tissue. Documentation for recent abnormal laboratory results was a hand written arrow downward and "Hgb [hemoglobin]" and "K [potassium]" not value assigned within the assessment nor where the information was obtained. The comprehensive assessment and the clinical record failed to evidence patient / caregiver education, measurement of learning, observation of the caregiver / patient technique, and a return demonstration to measure education deficits related to medication administration via PICC and wound care and any further education required with a			

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	clear delineation as to what tasks the patient / caregiver was capable of completing and which tasks the nurse was to complete. B. On a document titled "MCD [Medicaid] Skilled Care Plan / Nursing Visit Note" of the same date, 4/16/14, stated, "Discharge from acute hosp [hospital] with ongoing extensive wound care needs including cont. [continuous] IV [intravenous] therapy - both requiring SN." The documentation indicated the plan was for the skilled nurse to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a week for 7 weeks, wound care per wound vacuum to be changed every 3 days, a laboratory draw - a basic metabolic profile on 4/18/14, 4/21/14, and 4/23/14, and to maintain PICC per protocol, sterile dressing change every 7 days. The record failed to evidence a physician was consulted and orders received for the plan as written by the RN, prior to implementation. The record failed to evidence a physician order for the IV antibiotics, dose, frequency, begin date, who could / would administer the medication, wound care orders, and orders for follow through on the low hemoglobin and potassium as noted on the comprehensive assessment.			

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	C. Skilled nurse visit note dated 4/17/14 completed by employee P, a licensed practical nurse stated, "IV ATB [antibiotic] ran per order ... PICC flushes." Employee C completed a skilled nurse visit at the same time and documented the Wound Visit Note Addendum which identified the left wound was with tunneling or undermining, was not specific which, 6.0 centimeters at 11 o ' clock, tunneling and / or undermining which was not documented on the comprehensive assessment, and documentation the left wound was dressed with green foam verse the black foam as written on the plan of care prior to applying the wound vacuum. The visit note and clinical record failed to evidence the physician was notified about the tunneling / undermining and the record failed to evidence a physician order for green foam to be used with the wound vacuum. The visit note and clinical record failed to evidence patient / caregiver education, measurement of learning, observation of caregiver / patient technique for the PICC care, IV administration, wound care procedures for level of education, any deficits and education needs, and a clear delineation which tasks the patient / caregiver was competent to complete. D. Skilled nurse visit note dated			

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	4/18/14 completed by employee C, a RN, indicated a blood draw was obtained from the PICC and the PICC line was flushed and locked with Heparin. The visit note failed to evidence who administered the IV medications, failed to include a wound assessment, failed to evidence a body systems assessment, a line was drawn through 50 % of the visit note and the systems assessment portion was left blank. The visit note indicated the skilled nurse visit lasted only 1/2 hour. The note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered or an order to reduce the duration of the skilled nurse visits. E. Skilled nurse visit note dated 4/19/14 completed by employee C stated, "Removed green foam dressing, cleansed with normal saline, filled with green foam." The documentation failed to evidence an assessment of the PICC line, an assessment of the right wound, and an assessment of all body systems - the portion of the nurse visit note was left blank. The visit note indicated the skilled nurse visit lasted only 1 hour. The note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered and failed to evidence an order to reduce the duration of the skilled nurse visits.			

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	F. Skilled nurse visit note dated 4/21/14 completed by employee C failed to evidence an assessment of the patient's body systems, the portion of the note was blank with a line drawn through, failed to evidence an assessment of the PICC access, and failed to assess the wound on the patient's right buttock The note indicated the dressing to the wound on the left buttock was changed and wound vacuum was attached. The visit note failed to evidence the laboratory draw was obtained as written on the plan of care. The visit note indicated the skilled nurse visit lasted only 3/4 of an hour. The note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered, and the record failed to evidence an order to reduce the duration of the skilled nurse visits. G. Skilled nurse visit note dated 4/22/14 completed by employee C addressed only the wound on the left and indicated the wound was tunneling or undermined [not specified] at 11 o ' clock. The documentation evidenced the nurse changed to wound dressing, applied green foam to the wound bed, and reattached the wound vacuum. The visit note indicated the skilled nurse visit lasted only 1 hour. The note and record failed to explain why the 2 hour skilled			

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	nurse visit was not completed as ordered, and the record failed to evidence an order to reduce the duration of the skilled nurse visits. H. Skilled nurse visit note dated 4/23/14, completed by employee P, that documented the wounds were not assessed during the visit and stated, "Assisted patient with IV ATB [antibiotics]." The plan of care indicated the antibiotic zosyn was ordered for 6 days beginning 4/16/14. The record failed to explain why the patient was infusing the antibiotic on the 7th day following the start of the antibiotic. The visit note indicated the skilled nurse visit lasted only 1 hour and 5 minutes, the note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered, and the record failed to evidence an order to reduce the duration of the skilled nurse visits. I. Skilled nurse visit note dated 4/24/14, completed by employee P, failed to evidence care was provided to the wound on the right and an assessment of either wound. Only the wound on the left was addressed within the notes - noted the dressing was changed. The visit note indicated the skilled nurse visit lasted only 1 hour and 10 minutes. The record failed to explain why the 2 hour skilled			

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	nurse visit was not completed as written on the plan of care. J. Skilled nurse visit note dated 4/25/14, completed by employee P, failed to evidence care was provided to the wound on the right and an assessment of either wound; only the wound on the left was addressed within the notes which noted the dressing was changed. The visit note indicated the skilled nurse visit lasted only 1 hour and 40 minutes. The record failed to explain why the 2 hour skilled nurse visit was not completed as written on the plan of care. K. Skilled nurse visit note dated 4/29/14, completed by employee P, evidenced the wound on the right buttock was healed and the wound on the left was now 17.0 centimeters in length X 4.0 cm width, no depth was documented and undermining / tunneling [not specified] was measured to be 6.0 cm at 11 o'clock, and a blood serum sample was collected from the PICC. The employee documented the wound on the left was packed with green foam and not the black foam as written on the plan of care. The visit note indicated the skilled nurse visit lasted only 1 hour and 10 minutes, the note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered, and failed to			

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	evidence an order to reduce the duration of the skilled nurse visits. L. Skilled nurse visit note dated 5/1/14, completed by employee P, indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care. M. Skilled nurse visit note dated 5/3/14, completed by employee P and indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care. N. Skilled nurse visit note dated 5/7/14, completed by employee C stated, "Patient released from overnight stay at hospital 5/6/14 to have abscess I & D [incision and drainage]. New wound and IV antibiotics." Documentation evidenced the wound on the left buttock was 14.0 cm length X 3.5 cm width X 0.3 cm depth and the wound on the right was 3.0 cm width X 1.5 cm length X 1.75 cm depth. The record included a Physician Order from Walgreens Infusion that listed the medication "Invanz 1 gram / 100 mL NS [normal saline] Mini Bag Plus" and the instructions were to "Activate bag as directed prior to each dose to dissolve completely, then infuse Invanz 1 GM /			

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	100 mL over 1 hour (100 mL / hr) once every 24 hours per PICC line via gravity set X 7 days." The documentation for the skilled nurse visit failed to evidence a full body systems assessment and an assessment of the PICC line was completed during the visit. The note stated, "Instructed on new antibiotic." The record failed to evidence orders for the new wound beds or that the attending physician was consulted regarding the new IV antibiotic orders and wound care. O. Skilled nurse visit note dated 5/8/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied. The wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. P. Skilled nurse visit note dated 5/10/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied. The wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. Q. The record failed to evidence			

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	the PICC access dressing was changed during week four of the certification period. Skilled nurse visits were completed on May 7, 8, and 10, 2014 . The documentation from these visits failed to evidence an assessment of the PICC access and a dressing change. The record failed to evidence an order to disregard the plan of care order for weekly dressing changes to the PICC access. 8. Clinical record #9, start of care (SOC) 5/15/14, included the signature of employee K on the referral form, and a verbal order dated 5/14/14 that evidenced employee K received an order from the attending for an evaluation and treatment by occupational therapy and physical therapy. A. The record evidenced employee H conducted the comprehensive assessment on 5/15/14 and employee L completed the occupational therapy assessment on 5/16/14. The plan of care for the certification period 5/15/14 through 7/13/14 signed by employee B on 5/12/14 included orders for physical therapy once a week for the first week and twice a week for the following four weeks and occupational therapy twice a week for two weeks and then once a week during			

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	week three. B. On 6/13/14 at 1:30 PM, employee K indicated when she signed the referral and verbal order she had not called the physician, she was signing that she intended to complete the comprehensive assessment. C. The clinical record failed to evidence the attending physician was consulted for orders to admit to the home health agency based on the needs identified in the comprehensive assessment and the treatment, interventions, and goals of the medical plan of care. 9. Clinical record # 10, SOC 3/17/14, included the medical plan of care dated 3/17/14 through 5/15/14 with orders for skilled nurse twice a week for week one and once a week for eight weeks, aide services twice a week for four weeks and once a week for the following five weeks, physical therapy twice a week for four weeks and once a week for four weeks and once during week nine, and speech therapy twice a week for eight weeks beginning week two of the certification period. The record evidenced that during week two of the certification period, one speech therapy visit was conducted, none were made during week			

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	three, and one during week seven. 10. Clinical record # 11, start of care 3/3/14, included a medical plan of care for the certification period 3/3/14 through 5/1/14 with orders for skilled nurse visits once a week for eight weeks and Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat. A. The record evidence the skilled nurse completed the comprehensive assessment on 3/3/14, the PT completed the their evaluation and began to treat on 3/5/14, and the OT completed their evaluation and began treatment on 3/4/14. The record failed to evidence the attending physician was consulted regarding the development of the medical plan of care based on the needs identified during the comprehensive and therapy assessment and treatment orders received. B. The record evidenced a Physician order dated 5/1/14 to complete a reassessment for the home health needs, skilled nurse services once a week for eight weeks begriming May 4, 2014. The order stated, "Area 5 non-skilled HHA [home health aide]" to begin week of May 4, 2014 for two hours, five days a week, for eight weeks. A re-assessment was conducted on 5/1/14 by a registered			

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	nurse which identified the patient continued to have a decubitus present and a follow up plan of care for the certification period 5/2/14 through 6/30/14 was developed with orders for skilled nursing weekly. The plan of care failed to include the aide services. The record failed to evidence the agency consulted with the attending physician to develop of the medical plan of care based on he findings of the comprehensive assessment and failed to evidence aide services were provided as noted on the 5/1/14 order. 11. On 6/12/14 at 2:08 PM, employee A indicated, when asked, the referral is obtained from the office nurse and that each discipline was to write the name of the attending on the assessment which was to prove they contacted the attending physician for treatment orders. 12. On 6/12/14 at 1:15 PM, employee O indicated he / she only places the name of the attending on the form but he does not contact the physician for treatment orders and that the office staff obtained the treatment orders. When asked to clarify, employee O indicated he / she was referring to the initial order obtained for the evaluation of the patient. 13. During a face to face interview on			

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	6/13/14 at 10:00 AM, employee M, indicated he / she completed comprehensive assessments and admitted patients for home health services. He / she indicated the office staff obtain the orders and the nurse in the field does not call for physician orders to treat the patient unless there was a concern or question. He/ she indicated when the clinician writes the name of the attending physician on the assessment document it is only referring to the initial order to evaluate the patient for home health services and is not indicating the disciple contacted the physician for treatment orders and for input in the development of the plan of care. 14. During a telephone interview on 6/13/14 at 12:30 PM, employee N indicated the initial physician order to evaluate for home health services was completed by office nurse named employee F. When asked if he / she calls the physician for initial treatment orders, employee N indicated he / she does not call the physician for treatment orders after completing the comprehensive assessment. He / she indicated the plan of care is written and sent to the physician and if the physician wishes to change the orders then they may at that time.			

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	15. On 6/13/14 at 3:32 PM, employee A indicated the process for missed visit notification was when the office staff find that a visit was missed, they write on a form titled "Confidential Fax Missed Visit (s) Medicare Patient" that the visit was missed and then the physician was notified by sending the form to the physician. She indicated the physician is not contacted by the discipline prior to the missed visit visit. She indicated the only requirement was to notify the physician of the missed visit.			
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.			

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	Based on clinical record and policy review and interview, the agency failed to ensure the plan of care covered all safety measures and was an accurate plan of care regarding the "Do Not Resuscitate" status of the 1 of 6 home visit patients (10) with the potential for patient harm for this patient and the ability to affect all the patients with advance directives and failed to ensure the plan of care was signed by the physician familiar with the patient for 1 of 12 records reviewed (#6) with the potential for patient harm. Findings: 1. Clinical record 10 evidenced physician orders for the certification period 3/17/14 through 5/15/14. The physician orders did not evidence a "Do Not Resuscitate" order. The principal diagnosis listed was Attention to Gastrostomy. A. A 2010 Smart Scribe Medical POC (Plan of Care)/485 Worksheet CM-3 dated 5/13/14 completed by registered nurse (RN), Employee G, indicated both the Full code and Do not resuscitate had been marked. At a later date the Do not resuscitate had been errored out by Employee G. A date was not present on the error out.	G000159	G159/N524-100% of all active patients were reviewed by the QI manager. A process was developed and each active chart was reviewed to ensure the DNR status was correct. Any chart found that did not have correct DNR/Code status was corrected by writing an MD order of clarification. A list of active patients was compiled to track the audit and ensure correct code status. This has been completed as of July 7, 14. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	07/13/2014

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	B. The physician orders for the certification period 5/16/14 through 7/14/14 states, "CODE STATUS: Do not resuscitate." The principal diagnosis is Dysphagia and orophargnyeal. C. The Home Health Aide Assignment Sheet dated 3/17/14 and 5/13/14 does not have a place to mark a whether the patient is to be resuscitated, leaving the aide to make their own decision. D. On 5/13/14 at 5:30 PM, the licensed speech therapist (ST), Employee I, evaluated the patient and re-certified the patient because "Patient demonstrates severe oropharyngeal dysphasia resulting in NPO (nothing by mouth) status. " E. On 6/13/14 at 11:10 AM, Alternate Director of Nursing, Employee F, indicated a coding error had been made that put a Do Not Resuscitate on the 485/Plan of Care. The software company picked up the Do Not Resuscitate coding. The physician signed the POC/485 as a Do Not Resuscitate. The patient is really a full code. Staff have been going to the home from 5/16/14 till today (6/13/14) under the impression the patient was a Do Not Resuscitate.			

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	F. The undated policy titled "Do Not Resuscitate Status" stated, "A written DNR order will be issued by the patient's primary physician (if DNR order originated during the patient's hospital stay, a new order must be obtained for use by the home health agency)." 2. Clinical record 6 evidenced a prescription written by an orthopedic physician and dated 5/13/14. The prescription ordered Lovanox [short term use anticoagulant to prevent clotting] 40 milligrams subcutaneous for 10 days, "post op [after surgery] ... P.T [physical therapy]: Strict TTWB [toe touch weight bearing] left lower extremity, hip precautions, if not complainant with weight bearing restriction, bed to chair transfers only, daily dressing changes, left hip with foam tape." A. The record included a plan of care for the certification period 5/15/14 through 7/13/14, start of care 5/15/14, contained two signatures on the plan of care name of the attending listed on the plan of care and the name of the nurse practitioner whom signed the plan of care. The plan of care failed to include the directions received from the orthopedic physician and the lovenox. B. A telephone interview with a			

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	representative of the clinic on 6/13/14 at 12:15 PM indicated the nurse practitioner, employee R, signed the patient's plan of care and the physician listed on the plan of care had never examined the patient. The physician listed was the medical director for the Indiana Health Center in Kokomo and the patient was only seen in the clinic by the nurse practitioner.			
G000160	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. Based on clinical record review and interview, the agency failed to ensure the physician was consulted to approve additions or modifications to the plan of care in 2 of 6 clinical records reviewed of patients receiving therapy. (1 and 6) The findings include: 1. Clinical record # 1, start of care 5/23/14, included a medical plan of care for the certification period 5/23/14 to 7/21/14 with orders for physical therapy (P.T.) to evaluate and treat by week 2 of	G000160	G160- Staff was given a plan of correction inservice notice that instructed them on contacting the MD with POC orders/modifications/additions. The disciplines were also told verbally of this need. The agency will ensure that all active charts will be reviewed by DON, ADON, or QI Manager for MD notification of POC by SN and/or therapists. If the review shows the MD was not contacted by being documented on page 1 of the disciplines careplan, then the MD will be contacted by phone by 7-11-14 and a clarification	07/13/2014

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	the certification period. The clinical record evidenced the P.T. evaluation was completed on 5/28/14 and treatments were provided on 6/3/14 and 6/6/14. The clinical record failed to evidence specific physician orders for the treatments. 2. Clinical record 6 evidenced a prescription, written by an orthopedic physician and dated 5/13/14, that ordered Lovenox [short term use, subcutaneous injectable anticoagulant to prevent clotting] 40 milligrams subcutaneous for 10 days, "post op [after surgery] ... P.T.: Strict TTWB [toe touch weight bearing] left lower extremity, hip precautions, if not complainant with weight bearing restriction, bed to chair transfers only, daily dressing changes, left hip with foam tape." A. The record included a verbal order written by employee N and dated 5/15/14 stated, "Home Health Care Services, skilled nurse Q O W [every other week] HHA 1-3 h 3 d w 1 [home health aide one to three hours three days a week for one week.] PT Eval and Treat." B. The comprehensive assessment was completed on 5/15/14 by employee N and failed evidence an attending physician was contacted for care and treatment orders.		order will be written that the MD was contacted regarding the development of the POC. 100% audit will be done by 7-11-14. This will be monitored ongoing on every new admit and recert by the DON and/or ADON with review of paperwork as it is turned in. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	

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	C. During a telephone interview on 6/13/14 at 12:30 PM, employee N indicated the initial physician order to evaluate for home health services was completed by office nurse, employee F. When asked if he / she calls the physician for initial treatment orders, employee N indicated that he / she does not call the physician for treatment orders with findings obtained from the comprehensive assessment. He / she indicated the plan of care is written and sent to the physician and if the physician wishes to change the orders then they may at that time. She indicated she typically works from the orders from the physician the patient most recently treated the patient, from an extended care facility or hospital. D. The record evidenced the physical therapist completed the evaluation on 5/23/14 and treatments were provided on May 23, 27, and 29 and June 3 and 5, 2014. The clinical record failed to evidence physician orders for the treatments. E. On 6/12/14 at 1:15 PM, employee O indicated he / she only places the name of the attending on the form but he does not contact the physician for treatment orders and the office staff obtained the			

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	treatment orders. When asked to clarify, employee O indicated he / she was referring to the initial order obtained for the evaluation of the patient. F. During a face to face interview on 6/13/14 at 10:00 AM, employee M, indicated he / she completed comprehensive assessments and admitted patients for home health services. He / she indicated the office staff obtain the orders and the nurse in the field does not call for physician orders to treat the patient unless there was a concern or question. He/ she indicated when the clinician writes the name of the attending physician on the assessment document it is only referring to the initial order to evaluate the patient for home health services and is not indicating the disciple contacted the physician for treatment orders and for input in the development of the plan of care. 3. The undated policy titled "Physician's Plan Of Treatment" number 2.18, stated, "A physician authorizes a plan of treatment prepared by the agency. Admission orders will be obtained prior to evaluation and treatment of the patient. ... Verbal orders may be accepted by professional nursing staff from a physician or staff nurse. They must be signed and dated within thirty (30) days.			

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	Verbal orders are to be recorded in the patient's clinical record by the professional receiving them. ... A physicians plan of care ... must include: The type and frequency of services needed, medications, specific orders for frequency or visits. ... Any changes to the physician's plan of treatment shall be reviewed by the attending physician."			
G000161	484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. Based on clinical record and policy review, the agency failed to ensure orders for therapy contained specific procedures and modalities to be used and the amount, frequency, and duration for 2 of 2 records reviewed of patients receiving therapy services with the potential to cause harm to all patients that receive therapy services. (#1 and 6) Findings: 1. Clinical record # 1, start of care 5/23/14, included a medical plan of care for the certification period 5/23/14 to 7/21/14 with orders for physical therapy	G000161	G161- Therapy staff was given a plan of correction inservice notice that instructed them on contacting the MD with POC orders/modifications/additions. Therapists were also told verbally of this need. The agency will ensure that 100% of active charts will be reviewed by DON, ADON, or QI Manager for MD notification of POC by therapists. If the review shows the MD was not contacted by being documented on page 1 of the therapists careplan, then the MD will be contacted by phone by 7-11-14 and a clarification order will be written that the MD was contacted regarding the	07/13/2014

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	(P.T.) to evaluate and treat by week 2 of the certification period. The clinical record evidenced the P.T. evaluation was completed on 5/28/14 and treatments were provided on 6/3/14 and 6/6/14. The clinical record failed to evidence specific physician orders for the treatments or specific procedures and modalities to be used and the amount, frequency, and duration. 2. Clinical record 6 evidenced a prescription, written by an orthopedic physician and dated 5/13/14, that ordered Lovenox [short term use, subcutaneous injectable anticoagulant to prevent clotting] 40 milligrams subcutaneous for 10 days, "post op [after surgery] ... P.T.: Strict TTWB [toe touch weight bearing] left lower extremity, hip precautions, if not complainant with weight bearing restriction, bed to chair transfers only, daily dressing changes, left hip with foam tape." The record evidenced the physical therapist completed the evaluation on 5/23/14 and treatments were provided on May 23, 27, and 29 and June 3 and 5, 2014. The clinical record failed to evidence physician orders for the treatments or specific procedures and modalities to be used and the amount, frequency, and duration. 3. The undated policy titled "Physician's		development of the POC. 100% audit will be done by 7-11-14. This will be monitored ongoing on every new admit and recert by the DON and/or ADON with review of paperwork as it is turned in. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	

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	Plan Of Treatment" number 2.18, stated, "A ... A physicians plan of care ... must include: The type and frequency of services needed, medications, specific orders for frequency or visits. ... Any changes to the physician's plan of treatment shall be reviewed by the attending physician."			
G000168	484.30 SKILLED NURSING SERVICES Based on clinical record and policy review and interview, it was determined the agency failed to ensure the nursing services were provided as ordered on the plan of care in 3 of 12 clinical records reviewed with the potential to effect all patients receiving nursing services (See G 170), failed to identify and address safety concerns in the patients home in 1 of 6 home visits observed (see G 172), failed to ensure the registered nurse initiated an accurate plan of care in 2 of 12 records reviewed with the potential for patient harm for this patient and the ability to affect all the patients (See G 173), and failed to ensure the registered nurse accurately initiated the "Do Not Resuscitate" status of the 1 of 6 home visit patients with the potential for patient	G000168	All nurses inserviced on how to initiate accurate plan of care covering all aspects of the POC and all requirements of medical plan of care. All staff will be oriented on all aspects of the medical plan of care to include admission orders and nursing and therapy orders for their care plans. Nursing staff will be educated on all requirements of medical plan of care. Nurses and therapists are to contact MD for orders on their care plan and it is to be documented on the first page of the care plan that the MD was called. The plan of care is sent to the MD for signature and is required to be signed in 30 days per regulations. The physician's signature of the POC is a confirmation that the nurs/therapist received verbal orders regarding conferring on	07/13/2014

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	harm for this patient and the ability to affect all the patients with advance directives (See G 175). The cumulative effect of these systemic problems resulted in the agency's inability to provide safe nursing care to meet the requirements of the Condition of Participation 484.30: Skilled Nursing Services.		the plan of care. The physician's signature is the authorization of MD orders for the POC. The DON and ADON will be responsible for orientation and education of staff. 20% of new and current charts will be audited by the QI manager for the next 2 months to ensure orders are present in the chart to meet regulations for the medical plan of care and then quarterly. The QI Manager will be responsible for monitoring these corrective actions to ensure the deficiency is corrected by July 13, 14 and will not reoccur.	
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 as ordered on the plan of care in 3 of 12 clinical records reviewed (1, 5, and 12) with the potential to effect all patients receiving nursing services. Findings: 1. Clinical record 12, start of care	G000170	G170/N537-100 % of charts will be audited by DON, ADON or QI manager related to MD orders and POC orders/modifications/additions by July 11, 14. Staff was given a plan of correction inservice notice that instructed them on contacting the MD with POC orders/modifications/additions. The disciplines were also told verbally of this need. Disciplines will ensure that they perform care under the MD order. Staff will be educated per	07/13/2014

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	5/19/14, failed to evidence a plan of care signed by the physician at the time of the survey on 6/13/14. A verbal order was obtained 5/19/14 for Home care evaluation and treat skilled nurse 2 times a week times 1 week, physical therapy evaluation and treat and occupational therapy evaluation and treat. The physician signed the verbal order 5/27/14. The clinical record evidenced skilled nurse visits without orders week 3 on 5/29/14 and week 4 on 6/2/14. Surveyor: Boston, Bridget 2. The undated policy titled "Medication Administration Guidelines" number 2.57 stated, "Antibiotics a. Nurses are only permitted to give the initial dose in the home with knowledge of the physician and specific orders for treatment of a reaction are provided by the physician. ... The nurse should observe the patient / client for any reaction for at least 30 minutes after the dose is given. ... Document medication administration by charting it in the patient / client's clinical record, to include: a. medication name, dose, route, ... c. medication date and time. ... Observe the patient / client for medication results and document, ... 1. Verify the physician order for medication administration. 2. Verify the date and time of the last medication administration		plan of correction inservice notice on consulting with the MD for every aspect of care to be provided and that care cannot deviate from a current order for Tx or meds. A new order must be obtained for any change. The MD will be contacted for all initial and ongoing treatment orders. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	

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	by checking the documentation in the patient / client record." 3. Clinical record 1, start of care (SOC), evidenced a plan of care for the certification period 5/23/14 through 6/11/14 with orders for skilled nurse once a week for eight weeks. Employee B signed the plan of care dated 5/21/14 indicating a verbal order was received for these orders on 5/21/14. The record failed to evidence the verbal order referenced. The record included a two page referral dated 5/21/14 which was signed by employee B. The referral did not include a verbal order as written on the plan of care. A. A physician order dated 5/23/14, written by employee K, indicated a verbal order was obtained from the attending physician for home health care evaluate and treat, skilled nurse one visit during week one. B. The record evidenced the occupational therapist completed an assessment on 5/31/14 and completed additional visits on June 2 and June 4, 2014. The record failed to evidence a physicians order for the occupational visits and the services provided. 4. Clinical record 5, start of care 4/16/14,			

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	included a medical plan of care for the certification period 4/16/14 through 6/16/14 with orders for skilled nursing to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a week for 7 weeks to assess / evaluate all body systems, wound care - right inner buttock, cleanse with normal saline, apply alginate and cover with mepilex daily, and wound care - left inner buttock - cleanse with normal saline, apply black sponge and wound vacuum at 125 mmHg, change every 3 days. The plan of care included an IV medication order for zosyn 2.25 milligrams to be administered every 8 hours for six days. The record failed to evidence a physician was consulted for wound treatment orders and the IV antibiotic orders as written on the plan of care. A. Skilled nurse visit note dated 4/17/14 completed by employee P, a licensed practical nurse stated, "IV ATB [antibiotic] ran per order ... PICC flushes." Employee C completed a skilled nurse visit at the same time and documented the Wound Visit Note Addendum which identified the left wound was with tunneling or undermining, was not specific which, 6.0 centimeters at 11 o ' clock, tunneling and / or undermining which was not			

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	documented on the comprehensive assessment, and documentation the left wound was dressed with green foam verse the black foam as written on the plan of care prior to applying the wound vacuum. The visit note and clinical record failed to evidence the physician was notified about the tunneling / undermining and the record failed to evidence a physician order for green foam to be used with the wound vacuum. The visit note and clinical record failed to evidence patient / caregiver education, measurement of learning, observation of caregiver / patient technique for the PICC care, IV administration, wound care procedures for level of education, any deficits and education needs, and a clear delineation which tasks the patient / caregiver was competent to complete. B. Skilled nurse visit note dated 4/18/14 completed by employee C, a RN, indicated a blood draw was obtained from the PICC and the PICC line was flushed and locked with Heparin. The visit note failed to evidence who administered the IV medications, failed to include a wound assessment, failed to evidence a body systems assessment, a line was drawn through 50 % of the visit note and the systems assessment portion was left blank.			

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	C. Skilled nurse visit note dated 4/19/14 completed by employee C stated, "Removed green foam dressing, cleansed with normal saline, filled with green foam." The documentation failed to evidence an assessment of the PICC line, an assessment of the right wound, and an assessment of all body systems - the portion of the nurse visit note was left blank. D. Skilled nurse visit note dated 4/21/14 completed by employee C failed to evidence an assessment of the patient's body systems, the portion of the note was blank with a line drawn through, failed to evidence an assessment of the PICC access, and failed to assess the wound on the patient's right buttock The note indicated the dressing to the wound on the left buttock was changed and wound vacuum was attached. The visit note failed to evidence the laboratory draw was obtained as written on the plan of care. E. Skilled nurse visit note dated 4/22/14 completed by employee C addressed only the wound on the left and indicated the wound was tunneling or undermined [not specified] at 11 o ' clock. The documentation evidenced the nurse changed to wound dressing, applied green foam to the wound bed, and			

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	reattached the wound vacuum. F. Skilled nurse visit note dated 4/23/14, completed by employee P, that documented the wounds were not assessed during the visit and stated, "Assisted patient with IV ATB [antibiotics]." The plan of care indicated the antibiotic zosyn was ordered for 6 days beginning 4/16/14. The record failed to explain why the patient was infusing the antibiotic on the 7th day following the start of the antibiotic. G. Skilled nurse visit note dated 4/24/14, completed by employee P, failed to evidence care was provided to the wound on the right and an assessment of either wound. Only the wound on the left was addressed within the notes - noted the dressing was changed. H. Skilled nurse visit note dated 4/25/14, completed by employee P, failed to evidence care was provided to the wound on the right and an assessment of either wound; only the wound on the left was addressed within the notes which noted the dressing was changed. I. Skilled nurse visit note dated 4/29/14, completed by employee P, evidenced the wound on the right buttock was healed and the wound on the left was			

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	now 17.0 centimeters in length X 4.0 cm width, no depth was documented and undermining / tunneling [not specified] was measured to be 6.0 cm at 11 o'clock, and a blood serum sample was collected from the PICC. The employee documented the wound on the left was packed with green foam and not the black foam as written on the plan of care. J. Skilled nurse visit note dated 5/1/14, completed by employee P, indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care. K. Skilled nurse visit note dated 5/3/14, completed by employee P and indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care. L. Skilled nurse visit note dated 5/7/14, completed by employee C stated, "Patient released from overnight stay at hospital 5/6/14 to have abscess I & D [incision and drainage]. New wound and IV antibiotics." Documentation evidenced the wound on the left buttock was 14.0 cm length X 3.5 cm width X 0.3 cm depth and the wound on the right was 3.0 cm width X 1.5 cm length X 1.75 cm			

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	depth. The record included a Physician Order from Walgreens Infusion that listed the medication "Invanz 1 gram / 100 mL NS [normal saline] Mini Bag Plus" and the instructions were to "Activate bag as directed prior to each dose to dissolve completely, then infuse Invanz 1 GM / 100 mL over 1 hour (100 mL / hr) once every 24 hours per PICC line via gravity set X 7 days." The documentation for the skilled nurse visit failed to evidence a full body systems assessment and an assessment of the PICC line was completed during the visit. The note stated, "Instructed on new antibiotic." The record failed to evidence orders for the new wound beds or that the attending physician was consulted regarding the new IV antibiotic orders and wound care. M. Skilled nurse visit note dated 5/8/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied. The wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. N. Skilled nurse visit note dated 5/10/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum			

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	applied. The wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. O. The record failed to evidence the PICC access dressing was changed during week four of the certification period. Skilled nurse visits were completed on May 7, 8, and 10, 2014 . The documentation from these visits failed to evidence an assessment of the PICC access and a dressing change. The record failed to evidence an order to disregard the plan of care order for weekly dressing changes to the PICC access. 6. On 6/12/14 at 2:08 PM, employee A indicated, when asked, the referral is obtained from the office nurse and that each discipline was to write the name of the attending on the assessment which was to prove they contacted the attending physician for treatment orders. 7. On 6/12/14 at 1:15 PM, employee O indicated he / she only places the name of the attending on the form but he does not contact the physician for treatment orders and that the office staff obtained the treatment orders. When asked to clarify, employee O indicated he / she was			

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	referring to the initial order obtained for the evaluation of the patient. 8. During a face to face interview on 6/13/14 at 10:00 AM, employee M, indicated he / she completed comprehensive assessments and admitted patients for home health services. He / she indicated the office staff obtain the orders and the nurse in the field does not call for physician orders to treat the patient unless there was a concern or question. He/ she indicated when the clinician writes the name of the attending physician on the assessment document it is only referring to the initial order to evaluate the patient for home health services and is not indicating the disciple contacted the physician for treatment orders and for input in the development of the plan of care. 9. During a telephone interview on 6/13/14 at 12:30 PM, employee N indicated the initial physician order to evaluate for home health services was completed by office nurse named employee F. When asked if he / she calls the physician for initial treatment orders, employee N indicated he / she does not call the physician for treatment orders after completing the comprehensive assessment. He / she indicated the plan of care is written and sent to the			

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COMFORT HOME HEALTH LLC	1815 S PLATE STREET KOKOMO, IN 46902

(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
	physician and if the physician wishes to change the orders then they may at that time.			
G000172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record review and observation, the agency failed to ensure the registered identified and addressed safety concerns in the patients home in 1 of 6 home visits observed (#1) creating the potential for the patient to fall and harm themself. The findings include: 1. On 6/11/14 at 4:30 PM, patient 1 was observed in the home. The patient lives alone in a ranch style home with private paid help during the day. The home visit was for physical therapy. The patient indicated the patient had fallen off the toilet extension earlier in the day. The connector to the toilet extension had given loose from the toilet and the	G000172	G172/N541-100 % of active charts will be reviewed by DON, ADON, or QI Manager to ensure that no safety issue is present in current charts. Education to pt/family/caregiver on safety is to be completed by skilled staff. Staff will be instructed to record safety issues on comprehensive assessment or visit note and will be re-instructed on the incident reporting policy. The DON and/or ADON will instruct the clinical staff on safety issue/incident reporting. The agency will ensure all pts are regularly evaluated and re-evaluated following any incident regarding pt safety, or any health concern. When the agency is aware of a safety concern or incident, an incident report is completed which includes notifying the MD of the incident. Staff are instructed to complete the incident report and	07/13/2014

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	extension had fallen to one side. The paid attendant had caught the patient before hitting the floor. The patient did not appear to be hurt. The paid attendant had not notified anyone. The patient had called a friend to come and put on different handles on the toilet. The handles attached directly to the back of the toilet through the lid holes. Upon inspection, both the new handles and the toilet extension are loose and tilt from side to side. The agency nurse stayed in the living room and did not come to the bathroom for the toilet inspection. The physical therapist assistant did come in. On 6/11/14 at 5:15 PM, the physical therapist assistant, Employee J, indicated the new bars and the toilet extension were not securely attached to the toilet. When the patient would try to get up and put more weight on one side than the other, they would tilt. 2. Clinical record 1, start of care (SOC) evidenced a plan of care for the certification period 5/23/14 through 6/11/14 with orders for skilled nurse once a week for eight weeks, physical therapy to evaluate and treat, and occupational therapy to evaluate and treat by the second week. The record failed to identify the lack of safety features in the patient's bathroom and that a plan had		notify the MD. Disciplines ongoing safety assessment is to be addressed on each visit. Ongoing chart audits are reviewed with quarterly record review by the QI manager. This will be completed by July 13, 14.	

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	been developed to prevent and reduce falls. The comprehensive assessment evidenced the patient was assessed to be at risk for falls with a score of 11. Greater than 10 was determined by the facility assessment form to be at high risk for falls.			
G000173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse initiated an accurate plan of care in 2 of 12 records reviewed with the potential for patient harm for this patient and the ability to affect all the patients. (5 and 10) Findings: 1. Clinical record 10 evidenced physician orders for the certification	G000173	G173/N542-100% of all active patients were reviewed by the QI manager. A process was developed and each active chart was reviewed to ensure the DNR status was correct. An active patient list was compiled to track the audit and ensure correct code status. Any chart found that did not have correct DNR/Code status was corrected by writing an MD order of clarification. A list was compiled to track the audit and ensure correct code status. This has been	07/13/2014

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	period 3/17/14 through 5/15/14. The physician orders did not evidence a Do Not Resuscitate order. The principal diagnosis listed is Attention to Gastrostomy. The plan of care indicated the patient was a Do Not Resuscitate status. A. A 2010 Smart Scribe Medical POC (Plan of Care)/485 Worksheet CM-3 dated 5/13/14 completed by registered nurse (RN), Employee G, indicated both the Full code and Do not resuscitate had been marked. At a later date the Do not resuscitate had been errored out by Employee G. A date was not present on the error out. B. The physician orders for the certification period 5/16/14 through 7/14/14 evidences "CODE STATUS: Do not resuscitate." C. The Home Health Aide Assignment Sheet dated 3/17/14 and 5/13/14 does not have a place to mark a resuscitation code, leaving the aide to make their own decision. D. On 6/13/14 at 11:10 AM, Alternate Director of Nursing, Employee F, indicated a coding error had been made that put a Do Not Resuscitate on the 485/Plan of Care. The software		completed as of July 7, 14. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	

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	company picked up the Do Not Resuscitate coding. The physician signed the POC/485 as a Do Not Resuscitate. The patient is really a full code. Staff have been going to the home from 5/16/14 till today (6/13/14) under the impression the patient was a Do Not Resuscitate. E. The undated policy titled "Do Not Resuscitate Status" stated, "A written DNR order will be issued by the patient's primary physician (if DNR order originated during the patient's hospital stay, a new order must be obtained for use by the home health agency)." 2. Clinical record 5, start of care 4/16/14, included a medical plan of care for the certification period 4/16/14 through 6/16/14 with orders for skilled nursing to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day for 3 days a week for 7 weeks to assess / evaluate all body systems, wound care - right inner buttock, cleanse with normal saline apply alginate and cover with mepilex daily, wound care - left inner buttock - cleanse with normal saline apply black sponge and wound vacuum at 125 mmHg and change every 3 days. The plan of care included an IV medication order zosyn 2.25 milligrams to be administered every 8 hours for six days. The record included			

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	a physician order dated 4/16/14 for home health evaluate and treat, written by employee K at 4:30 PM. The record failed to evidence a physician was consulted for the wound treatment orders and the IV antibiotic orders as written on the plan of care. A. On a document titled "MCD [Medicaid] Skilled Care Plan / Nursing Visit Note" of the same date, 4/16/14, stated, "Discharge from acute hosp [hospital] with ongoing extensive wound care needs including cont. [continuous] IV [intravenous] therapy - both requiring SN." The documentation indicated the plan was for the skilled nurse to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a week for 7 weeks; wound care per wound vacuum, to be changed every 3 days; a laboratory draw, a basic metabolic profile on 4/18/14, 4/21/14, and 4/23/14; and to maintain PICC per protocol with sterile dressing change every 7 days. The record failed to evidence a physician was consulted and orders received for the plan as written by the RN which included physician order for the IV antibiotics, wound care orders, and orders for follow through on the low hemoglobin and potassium as noted on the comprehensive assessment.			

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	B. Skilled nurse visit notes dated 5/1/14 and 5/3/14 completed by employee P indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care. The record failed to evidence a change to the plan of care. C. Skilled nurse visit note dated 5/7/14 completed by employee C stated, "Patient released from overnight stay at hospital 5/6/14 to have abscess I & D [incision and drainage]. New wound and IV antibiotics." Documentation evidenced the wound on the left buttock was 14.0 cm length X 3.5 cm width X 0.3 cm depth and the wound on the right was 3.0 cm width X 1.5 cm length X 1.75 cm depth. The record included a Physician Order from Walgreens Infusion that listed the medication "Invanz 1 gram / 100 mL NS [normal saline] Mini Bag Plus" and the instructions "Activate bag as directed prior to each dose to dissolve completely, then infuse Invanz 1 GM / 100 mL over 1 hour (100 mL / hr) once every 24 hours per PICC line via gravity set X 7 days." The record failed to evidence physician orders for the new wound beds and that the attending physician was consulted regarding the new IV antibiotic orders and wound care.			

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	D. Skilled nurse visit note dated 5/8/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied and that the wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. E. Skilled nurse visit note dated 5/10/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied and that the wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. F. During a face to face interview on 6/13/14 at 10:00 AM, employee M, indicated he / she completed comprehensive assessments and admitted patients for home health services. He / she indicated the office staff obtain the orders and the nurse in the field does not call for physician orders to treat the patient unless there was a concern or question. He/ she indicated when the clinician writes the name of the attending physician on the assessment document it is only referring to the initial order to evaluate the patient for home health			

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	services and is not indicating that the disciple contacted the physician for treatment orders and for input in the development of the plan of care. G. During a telephone interview on 6/13/14 at 12:19 PM, employee N indicated the initial physician order to evaluate for home health services was completed by office nurse and named employee F. When asked if he / she calls the physician for initial treatment orders, employee N indicated that he / she does not call the physician for treatment orders after completing the comprehensive assessment. He / she indicated the plan of care is written and sent to the physician and if the physician wishes to change the orders then they may at that time.			
G000175	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse accurately	G000175	G175/N543-100% of all active patients were reviewed by the QI manager. A process was developed and each active chart was reviewed	07/13/2014

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	initiated the "Do Not Resuscitate" status of the 1 of 6 home visit patients (10) with the potential for patient harm for this patient and the ability to affect all the patients with advance directives. Findings: 1. Clinical record 10 evidenced physician orders for the certification period 3/17/14 through 5/15/14. The physician orders did not evidence a "Do Not Resuscitate" order. The principal diagnosis listed was Attention to Gastrostomy. 2. A 2010 Smart Scribe Medical POC (Plan of Care)/485 Worksheet CM-3 dated 5/13/14 completed by registered nurse (RN), Employee G, indicated both the Full code and Do not resuscitate had been marked. At a later date the Do not resuscitate had been errored out by Employee G. A date was not present on the error out. 3. The physician orders for the certification period 5/16/14 through 7/14/14 states, "CODE STATUS: Do not resuscitate." The principal diagnosis is Dysphagia and orophargnyeal. 4. The Home Health Aide Assignment Sheet dated 3/17/14 and 5/13/14 does not		to ensure the DNR status was correct. An active patient list was compiled to track the audit and ensure correct code status. Any chart found that did not have correct DNR/Code status was corrected by writing an MD order of clarification. A list was compiled to track the audit and ensure correct code status. This has been completed as of July 7, 14. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	

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	have a place to mark a whether the patient is to be resuscitated, leaving the aide to make their own decision. 5. On 5/13/14 at 5:30 PM, the licensed speech therapist (ST), Employee I, evaluated the patient and re-certified the patient because "Patient demonstrates severe oropharyngeal dysphasia resulting in NPO (nothing by mouth) status. " 6. On 6/13/14 at 11:10 AM, Alternate Director of Nursing, Employee F, indicated a coding error had been made that put a Do Not Resuscitate on the 485/Plan of Care. The software company picked up the Do Not Resuscitate coding. The physician signed the POC/485 as a Do Not Resuscitate. The patient is really a full code. Staff have been going to the home from 5/16/14 till today (6/13/14) under the impression the patient was a Do Not Resuscitate. 7. The undated policy titled "Do Not Resuscitate Status" stated, "A written DNR order will be issued by the patient's primary physician (if DNR order originated during the patient's hospital stay, a new order must be obtained for use by the home health agency)."			

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G000224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on clinical record review and interview, the agency failed to ensure the home health aide written care instructions were updated in relation to the patient having been assessed and found to have skin breakdown in 2 of 7 records reviewed of patients that received home health services (# 3 and 6) creating the potential to affect all of the agency's current patients receiving home health aide services. Findings include: 1. Clinical record number 3 included a plan of care dated 5/20/14 to 7/18/14 for home health aide services 6 - 10 hours a day for 3 - 6 days a week throughout the certification period. The plan of care failed to evidence specific duties to be performed by the home health aide.	G000224	G224-Staff will be educated on updating the home health aide written instructions/careplan with change of condition, safety precautions and specific duties. 100% of charts will be audited by DON/ADON/QI manager by July 11, 14 to ensure that the HHA careplan is updated at least every 60 days. Quarterly QI review will continue to audit HHA careplans for compliance. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	07/13/2014

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	The record included a home health aide assignment sheet signed and dated by the Registered Nurse on 1/16/14, 3/19/14, and 5/15/14 that failed to evidence updated instructions to the aide to prevent further skin breakdown of the heels and other bony prominences. 2. Clinical record 6 evidenced a prescription, written by an orthopedic physician dated 5/13/14. The prescription ordered Lovenox [short term use anticoagulant to prevent clotting] 40 milligrams subcutaneous for 10 days, "post op [after surgery] ... P.T.[physical therapy]: Strict TTWB [toe touch weight bearing] left lower extremity, hip precautions, if not complainant with weight bearing restriction, bed to chair transfers only, daily dressing changes, left hip with foam tape." The record failed to evidence the home health aide was instructed on safety precautions to take while assisting the patient. The aide assignment sheet dated 5/15/14 indicated the patient was post left hip replacement / revision and stated, "Assist pt [patient] to become more independent." 3. On June 12, 2014, at 5:10 PM, employee A indicated the information was not on the assignment sheet and the			

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	information on the prescription was pre-admit and not acted upon.			
G000229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days in 1 of 6 records reviewed of patients who received skilled and home health aide services longer than 14 days (# 6). Findings include: 1. The undated agency policy titled "Home Health Aide Supervisory Visits" number 2.49 stated, "When a patient / client is receiving skilled services, a home health care RN or therapist will make a supervisory visit to the patient's / client's residence at least every 14 days." 2. Clinical record 6 included a verbal order written by employee N dated	G000229	DON and ADON will educate nursing and therapy staff on timeliness of supervisory visits. The QI manager will audit 20% of new and current charts monthly for the next year to ensure supervisory visits are done by the RN or therpist in accordance with the regulation. DON, ADON and QI manager are responsible. The deficiency will be corrected by July 13, 14.	07/13/2014

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	5/15/14 stated, "Home Health Care Services, skilled nurse Q O W [every other week] HHA 1-3 h 3 d w 1 [home health aide one to three hours a day three days a week for one week.] PT Eval [physical therapy evaluation] and Treat." Home health aide visit notes evidenced aides services were provided by employee Q, HHA, 4 hours a day from May 15 through 31, 2014. The record evidenced the physical therapist completed the evaluation on 5/23/14 and treatments were provided on May 23, 27, and 29 and June 3 and 5, 2014. The clinical record failed to evidence the physical therapist or a skilled nurse conducted a supervisory visit at least every 14 days. 3. On June 12, 2014, at 5:10 PM, employee A indicated there was no further information to evidence for this record.			
G000337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must 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.			

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	Based on clinical record review, the agency failed to assess and identify all the patients medications during the comprehensive assessment in 1 of 11 skilled patient records reviewed with admission during 2014. (6) The findings are: Clinical record 6 evidenced a prescription, written by an orthopedic physician and dated 5/13/14. The prescription ordered Lovanox [short term use anticoagulant to prevent clotting] 40 milligrams subcutaneous for 10 days. The comprehensive assessment was completed on 5/15/14 by employee N. The assessment failed to include the lovenox. The medication review did not include the lovenox.	G000337	G337-100% of admission/recert charts are audited by the DON/ADON. The RN case manager is reviewing 100% of the pt meds in the home upon admission, recert and any change that occurs. The meds are entered into the med profile and are printed out for the RN case manager to review and sign and placed in the chart. Meds are updated as needed into the system and placed in the chart upon updating. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	07/13/2014
N000000	This was a state home health relicensure survey. Survey dates: June 11, 12 and 13, 2014	N000000		

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	Facility #:: 012349 Medicaid #: 201004280 Surveyors: Bridget Boston, RN, PHNS Lead Surveyor Susan E. Sparks, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN June 20, 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, and documented for all skilled care, services, and treatments to be provided in 7 of 12 clinical records reviewed (1, 2, 5, 9, 10, 11, and 12) with the potential to effect all current 150 patients. Findings: 1. On 6/11/14 at 1:20 PM, a co-owner,	N000522	G158/N522- The agency will ensure that all active patient charts will be reviewed by DON, ADON or QI Manager for MD notification of POC by SN and/or therapists. If the review shows the MD was not contacted by being documented on page 1 of the disciplines careplan, then the MD will be contacted by phone by 7-11-14 and a clarification order will be written that the MD was contacted regarding the development of the POC. This will be monitored ongoing on every new admit and recert by the DON and/or ADON with review of paperwork as it is turned in. The DON and ADON will be responsible for orientation and education of staff. 20% of charts	07/13/2014

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	Employee S, indicated the agency used at least two software programs for the electronic health records, one specifically for medicare patients, and one specifically for medicaid patients, and indicated the surveyors would not be granted a read only access to the electronic clinical records; access would be through the staff. 2. Clinical record 12, start of care 5/19/14, failed to evidence a plan of care signed by the physician at the time of the survey on 6/13/14. A verbal order was obtained 5/19/14 for Home care evaluation and treat skilled nurse 2 times a week times 1 week, physical therapy evaluation and treat and occupational therapy evaluation and treat. The physician signed the verbal order 5/27/14. A. The physical therapy evaluation was performed 5/24/14 with requested visits 1 times week times 1 week, 2 times week times 4 weeks, then 1 time for 1 week. The physical therapy form did not indicate the physician had been notified and the physician had not signed the physical therapy order for visits. B. The occupation therapy evaluation was performed 5/20/14 with requested visits 2 times week times 2 weeks and 1		will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	

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	times a week times 3 weeks. The occupational therapy form did not indicate the physician had been notified and the physician had not signed the occupational therapy order for visits. C. The clinical record evidenced skilled nurse visits without orders week 3 on 5/29/14 and week 4 on 6/2/14; physical therapy visits without orders week 3 on 5/28/14 and 5/30/14 and week 4 on 6/3/14 and 6/5/14; and occupational therapy visits without orders week 3 on 5/27/14 and 5/29/14 and week 4 on 6/3/14. 3. The undated policy titled "Physician's Plan Of Treatment" number 2.18, stated, "A physician authorizes a plan of treatment prepared by the agency. Admission orders will be obtained prior to evaluation and treatment of the patient. ... Verbal orders may be accepted by professional nursing staff from a physician or staff nurse. They must be signed and dated within thirty (30) days. Verbal orders are to be recorded in the patient's clinical record by the professional receiving them. ... A physicians plan of care ... must include: The type and frequency of services needed, medications, specific orders for frequency or visits. ... Any changes to			

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	the physician's plan of treatment shall be reviewed by the attending physician." 4. The undated policy titled "Medication Administration Guidelines" number 2.57 stated, "Antibiotics a. Nurses are only permitted to give the initial dose in the home with knowledge of the physician and specific orders for treatment of a reaction are provided by the physician. ... The nurse should observe the patient / client for any reaction for at least 30 minutes after the dose is given. ... Document medication administration by charting it in the patient / client's clinical record, to include: a. medication name, dose, route, ... c. medication date and time. ... Observe the patient / client for medication results and document, ... 1. Verify the physician order for medication administration. 2. Verify the date and time of the last medication administration by checking the documentation in the patient / client record." 5. Clinical record 1, start of care (SOC) evidenced a plan of care for the certification period 5/23/14 through 6/11/14 with orders for skilled nurse once a week for eight weeks, physical therapy to evaluate and treat, and occupational therapy to evaluate and treat by the second week. Employee B signed the plan of care and dated 5/21/14 indicating			

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	a verbal order was received for these orders on 5/21/14. The record failed to evidence the verbal order referenced. A. The record included a two page referral dated 5/21/14 which was signed by employee B. The referral did not include a verbal order as written on the plan of care. B. A physician order dated 5/23/14, written by employee K, indicated a verbal order was obtained from the attending physician for home health care evaluate and treat, skilled nurse one visit during week one, and physical therapy and occupational therapy to evaluate and treat the week of May 25, 2014 . C. The record evidenced the occupational therapist completed an assessment on 5/31/14 and completed additional visits on June 2 and June 4, 2014. The record failed to evidence a physicians order for the occupational visits and the services provided. 6. Clinical record # 2, SOC 2/21/14, included a physician order dated 4/17/14 at 3 PM that indicated the order was for the recertification for Home Health Care. Skilled nursing was ordered once a week for 9 weeks, aide services were to be			

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	provided twice a week for nine weeks, and occupational and physical therapy were to evaluate and treat. A. The record included a medical plan of care for the certification period 4/22/14 through 6/20/14 with orders for the skilled nurse services once a week for nine weeks, aide services twice a week for nine weeks, physical therapy services twice a week for four weeks then once a week for two weeks, and occupational therapy once a week for two weeks, twice a week for two weeks, and once a week for two weeks. B. The record evidenced the physical therapist reassessed the patient on 4/15/14, seven days prior to the start of the certification period. The record failed to evidence an assessment by physical therapy occurred on or after the date of the physician order to assess dated 4/17/14. The record failed to evidence two visits were made during week four of the certification period. The record indicated one visit was made on May 14, 2014. C. The record failed to evidence any aide visits / services were provided during week one of the certification period.			

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	D. The record failed to evidence the occupation therapy services were provided as ordered. There were no occupational visits made during week one. 7. Clinical record 5, start of care 4/16/14, included a medical plan of care for the certification period 4/16/14 through 6/16/14 with orders for skilled nursing to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a week for 7 weeks to assess / evaluate all body systems, wound care - right inner buttock, cleanse with normal saline, apply alginate and cover with mepilex daily, and wound care - left inner buttock - cleanse with normal saline, apply black sponge and wound vacuum at 125 mmHg, change every 3 days. The plan of care included an IV medication order for zosyn 2.25 milligrams to be administered every 8 hours for six days. The record included a physician order dated 4/16/14 for home health evaluate and treat, written by employee K at 4:30 PM. The record failed to evidence a physician was consulted for wound treatment orders and the IV antibiotic orders as written on the plan of care. A. The record included a comprehensive assessment dated 4/16/14, completed by employee K, that indicated			

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	the visit occurred between 7:15 PM and 9:15 PM, included the diagnoses of necrotizing fasciitis and acute renal failure. The patient had been discharged from the hospital the same day, 4/16/14, assessed to have a peripherally inserted central catheter [PICC] line inserted on 4/9/14 at the left antecubital space, no arm circumference or the length of the tubing exposed was documented, and lack of knowledge related to medication administration was identified and documented. Post operative surgical debridement of wounds during the hospitalization - wound description on the left inner buttock / perineum was 16.5 centimeters (cm) width X 3.3 cm length X 1.8 cm depth, 20 percent eschar and 80 % granulating tissue and the wound on the right inner buttock was 2.4 cm width 0.6 cm length X 0.4 cm depth 15 % slough / eschar and 85 % granulating tissue. Documentation for recent abnormal laboratory results was a hand written arrow downward and "Hgb [hemoglobin]" and "K [potassium]" not value assigned within the assessment nor where the information was obtained. The comprehensive assessment and the clinical record failed to evidence patient / caregiver education, measurement of learning, observation of the caregiver / patient technique, and a return demonstration to measure education			

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	deficits related to medication administration via PICC and wound care and any further education required with a clear delineation as to what tasks the patient / caregiver was capable of completing and which tasks the nurse was to complete. B. On a document titled "MCD [Medicaid] Skilled Care Plan / Nursing Visit Note" of the same date, 4/16/14, stated, "Discharge from acute hosp [hospital] with ongoing extensive wound care needs including cont. [continuous] IV [intravenous] therapy - both requiring SN." The documentation indicated the plan was for the skilled nurse to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a week for 7 weeks, wound care per wound vacuum to be changed every 3 days, a laboratory draw - a basic metabolic profile on 4/18/14, 4/21/14, and 4/23/14, and to maintain PICC per protocol, sterile dressing change every 7 days. The record failed to evidence a physician was consulted and orders received for the plan as written by the RN, prior to implementation. The record failed to evidence a physician order for the IV antibiotics, dose, frequency, begin date, who could / would administer the medication, wound care orders, and orders for follow through on the low			

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	hemoglobin and potassium as noted on the comprehensive assessment. C. Skilled nurse visit note dated 4/17/14 completed by employee P, a licensed practical nurse stated, "IV ATB [antibiotic] ran per order ... PICC flushes." Employee C completed a skilled nurse visit at the same time and documented the Wound Visit Note Addendum which identified the left wound was with tunneling or undermining, was not specific which, 6.0 centimeters at 11 o ' clock, tunneling and / or undermining which was not documented on the comprehensive assessment, and documentation the left wound was dressed with green foam verse the black foam as written on the plan of care prior to applying the wound vacuum. The visit note and clinical record failed to evidence the physician was notified about the tunneling / undermining and the record failed to evidence a physician order for green foam to be used with the wound vacuum. The visit note and clinical record failed to evidence patient / caregiver education, measurement of learning, observation of caregiver / patient technique for the PICC care, IV administration, wound care procedures for level of education, any deficits and education needs, and a clear delineation which tasks the patient /			

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	caregiver was competent to complete. D. Skilled nurse visit note dated 4/18/14 completed by employee C, a RN, indicated a blood draw was obtained from the PICC and the PICC line was flushed and locked with Heparin. The visit note failed to evidence who administered the IV medications, failed to include a wound assessment, failed to evidence a body systems assessment, a line was drawn through 50 % of the visit note and the systems assessment portion was left blank. The visit note indicated the skilled nurse visit lasted only 1/2 hour. The note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered or an order to reduce the duration of the skilled nurse visits. E. Skilled nurse visit note dated 4/19/14 completed by employee C stated, "Removed green foam dressing, cleansed with normal saline, filled with green foam." The documentation failed to evidence an assessment of the PICC line, an assessment of the right wound, and an assessment of all body systems - the portion of the nurse visit note was left blank. The visit note indicated the skilled nurse visit lasted only 1 hour. The note and record failed to explain why the 2 hour skilled nurse visit was not			

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	completed as ordered and failed to evidence an order to reduce the duration of the skilled nurse visits. F. Skilled nurse visit note dated 4/21/14 completed by employee C failed to evidence an assessment of the patient's body systems, the portion of the note was blank with a line drawn through, failed to evidence an assessment of the PICC access, and failed to assess the wound on the patient's right buttock The note indicated the dressing to the wound on the left buttock was changed and wound vacuum was attached. The visit note failed to evidence the laboratory draw was obtained as written on the plan of care. The visit note indicated the skilled nurse visit lasted only 3/4 of an hour. The note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered, and the record failed to evidence an order to reduce the duration of the skilled nurse visits. G. Skilled nurse visit note dated 4/22/14 completed by employee C addressed only the wound on the left and indicated the wound was tunneling or undermined [not specified] at 11 o ' clock. The documentation evidenced the nurse changed to wound dressing, applied green foam to the wound bed, and reattached the wound vacuum. The visit			

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	note indicated the skilled nurse visit lasted only 1 hour. The note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered, and the record failed to evidence an order to reduce the duration of the skilled nurse visits. H. Skilled nurse visit note dated 4/23/14, completed by employee P, that documented the wounds were not assessed during the visit and stated, "Assisted patient with IV ATB [antibiotics]." The plan of care indicated the antibiotic zosyn was ordered for 6 days beginning 4/16/14. The record failed to explain why the patient was infusing the antibiotic on the 7th day following the start of the antibiotic. The visit note indicated the skilled nurse visit lasted only 1 hour and 5 minutes, the note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered, and the record failed to evidence an order to reduce the duration of the skilled nurse visits. I. Skilled nurse visit note dated 4/24/14, completed by employee P, failed to evidence care was provided to the wound on the right and an assessment of either wound. Only the wound on the left was addressed within the notes - noted the dressing was changed. The visit note			

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	indicated the skilled nurse visit lasted only 1 hour and 10 minutes. The record failed to explain why the 2 hour skilled nurse visit was not completed as written on the plan of care. J. Skilled nurse visit note dated 4/25/14, completed by employee P, failed to evidence care was provided to the wound on the right and an assessment of either wound; only the wound on the left was addressed within the notes which noted the dressing was changed. The visit note indicated the skilled nurse visit lasted only 1 hour and 40 minutes. The record failed to explain why the 2 hour skilled nurse visit was not completed as written on the plan of care. K. Skilled nurse visit note dated 4/29/14, completed by employee P, evidenced the wound on the right buttock was healed and the wound on the left was now 17.0 centimeters in length X 4.0 cm width, no depth was documented and undermining / tunneling [not specified] was measured to be 6.0 cm at 11 o'clock, and a blood serum sample was collected from the PICC. The employee documented the wound on the left was packed with green foam and not the black foam as written on the plan of care. The visit note indicated the skilled nurse visit lasted only 1 hour and 10 minutes, the			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT HOME HEALTH LLC	1815 S PLATE STREET KOKOMO, IN 46902

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	note and record failed to explain why the 2 hour skilled nurse visit was not completed as ordered, and failed to evidence an order to reduce the duration of the skilled nurse visits. L. Skilled nurse visit note dated 5/1/14, completed by employee P, indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care. M. Skilled nurse visit note dated 5/3/14, completed by employee P and indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care. N. Skilled nurse visit note dated 5/7/14, completed by employee C stated, "Patient released from overnight stay at hospital 5/6/14 to have abscess I & D [incision and drainage]. New wound and IV antibiotics." Documentation evidenced the wound on the left buttock was 14.0 cm length X 3.5 cm width X 0.3 cm depth and the wound on the right was 3.0 cm width X 1.5 cm length X 1.75 cm depth. The record included a Physician Order from Walgreens Infusion that listed the medication "Invanz 1 gram / 100 mL NS [normal saline] Mini Bag Plus" and			

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	the instructions were to "Activate bag as directed prior to each dose to dissolve completely, then infuse Invanz 1 GM / 100 mL over 1 hour (100 mL / hr) once every 24 hours per PICC line via gravity set X 7 days." The documentation for the skilled nurse visit failed to evidence a full body systems assessment and an assessment of the PICC line was completed during the visit. The note stated, "Instructed on new antibiotic." The record failed to evidence orders for the new wound beds or that the attending physician was consulted regarding the new IV antibiotic orders and wound care. O. Skilled nurse visit note dated 5/8/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied. The wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. P. Skilled nurse visit note dated 5/10/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied. The wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician			

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	order for the wound care provided. Q. The record failed to evidence the PICC access dressing was changed during week four of the certification period. Skilled nurse visits were completed on May 7, 8, and 10, 2014 . The documentation from these visits failed to evidence an assessment of the PICC access and a dressing change. The record failed to evidence an order to disregard the plan of care order for weekly dressing changes to the PICC access. 8. Clinical record #9, start of care (SOC) 5/15/14, included the signature of employee K on the referral form, and a verbal order dated 5/14/14 that evidenced employee K received an order from the attending for an evaluation and treatment by occupational therapy and physical therapy. A. The record evidenced employee H conducted the comprehensive assessment on 5/15/14 and employee L completed the occupational therapy assessment on 5/16/14. The plan of care for the certification period 5/15/14 through 7/13/14 signed by employee B on 5/12/14 included orders for physical therapy once a week for the first week and twice a			

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	week for the following four weeks and occupational therapy twice a week for two weeks and then once a week during week three. B. On 6/13/14 at 1:30 PM, employee K indicated when she signed the referral and verbal order she had not called the physician, she was signing that she intended to complete the comprehensive assessment. C. The clinical record failed to evidence the attending physician was consulted for orders to admit to the home health agency based on the needs identified in the comprehensive assessment and the treatment, interventions, and goals of the medical plan of care. 9. Clinical record # 10, SOC 3/17/14, included the medical plan of care dated 3/17/14 through 5/15/14 with orders for skilled nurse twice a week for week one and once a week for eight weeks, aide services twice a week for four weeks and once a week for the following five weeks, physical therapy twice a week for four weeks and once a week for four weeks and once during week nine, and speech therapy twice a week for eight weeks beginning week two of the certification period. The record evidenced that			

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	during week two of the certification period, one speech therapy visit was conducted, none were made during week three, and one during week seven. 10. Clinical record # 11, start of care 3/3/14, included a medical plan of care for the certification period 3/3/14 through 5/1/14 with orders for skilled nurse visits once a week for eight weeks and Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat. A. The record evidence the skilled nurse completed the comprehensive assessment on 3/3/14, the PT completed the their evaluation and began to treat on 3/5/14, and the OT completed their evaluation and began treatment on 3/4/14. The record failed to evidence the attending physician was consulted regarding the development of the medical plan of care based on the needs identified during the comprehensive and therapy assessment and treatment orders received. B. The record evidenced a Physician order dated 5/1/14 to complete a reassessment for the home health needs, skilled nurse services once a week for eight weeks begriming May 4, 2014. The order stated, "Area 5 non-skilled HHA [home health aide]" to begin week			

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	of May 4, 2014 for two hours, five days a week, for eight weeks. A re-assessment was conducted on 5/1/14 by a registered nurse which identified the patient continued to have a decubitus present and a follow up plan of care for the certification period 5/2/14 through 6/30/14 was developed with orders for skilled nursing weekly. The plan of care failed to include the aide services. The record failed to evidence the agency consulted with the attending physician to develop of the medical plan of care based on he findings of the comprehensive assessment and failed to evidence aide services were provided as noted on the 5/1/14 order. 11. On 6/12/14 at 2:08 PM, employee A indicated, when asked, the referral is obtained from the office nurse and that each discipline was to write the name of the attending on the assessment which was to prove they contacted the attending physician for treatment orders. 12. On 6/12/14 at 1:15 PM, employee O indicated he / she only places the name of the attending on the form but he does not contact the physician for treatment orders and that the office staff obtained the treatment orders. When asked to clarify, employee O indicated he / she was referring to the initial order obtained for			

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	the evaluation of the patient. 13. During a face to face interview on 6/13/14 at 10:00 AM, employee M, indicated he / she completed comprehensive assessments and admitted patients for home health services. He / she indicated the office staff obtain the orders and the nurse in the field does not call for physician orders to treat the patient unless there was a concern or question. He/ she indicated when the clinician writes the name of the attending physician on the assessment document it is only referring to the initial order to evaluate the patient for home health services and is not indicating the disciple contacted the physician for treatment orders and for input in the development of the plan of care. 14. During a telephone interview on 6/13/14 at 12:30 PM, employee N indicated the initial physician order to evaluate for home health services was completed by office nurse named employee F. When asked if he / she calls the physician for initial treatment orders, employee N indicated he / she does not call the physician for treatment orders after completing the comprehensive assessment. He / she indicated the plan of care is written and sent to the physician and if the physician wishes to			

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	change the orders then they may at that time. 15. On 6/13/14 at 3:32 PM, employee A indicated the process for missed visit notification was when the office staff find that a visit was missed, they write on a form titled "Confidential Fax Missed Visit (s) Medicare Patient" that the visit was missed and then the physician was notified by sending the form to the physician. She indicated the physician is not contacted by the discipline prior to the missed visit visit. She indicated the only requirement was to notify the physician of the missed visit.			
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.			

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	(iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record and policy review and interview, the agency failed to ensure the plan of care covered all safety measures and was an accurate plan of care regarding the "Do Not Resuscitate" status of the 1 of 6 home visit patients (10) with the potential for patient harm for this patient and the ability to affect all the patients with advance directives, failed to ensure the plan of care was signed by the physician familiar with the patient for 1 of 12 records reviewed (#6) with the potential for patient harm, and failed to ensure therapy orders included modalities specifying length of treatment for 2 of 2 records reviewed of patient with therapy services with the potential for harm to all patients receiving therapy services (#1 and 6). Findings: 1. Clinical record 10 evidenced	N000524	G159/N524-100% of all active patients were reviewed by the QI manager. A process was developed and each active chart was reviewed to ensure the DNR status was correct. Any chart found that did not have correct DNR/Code status was corrected by writing an MD order of clarification. A list of active patients was compiled to track the audit and ensure correct code status. This has been completed as of July 7, 14. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	07/13/2014

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	physician orders for the certification period 3/17/14 through 5/15/14. The physician orders did not evidence a "Do Not Resuscitate" order. The principal diagnosis listed was Attention to Gastrostomy. A. A 2010 Smart Scribe Medical POC (Plan of Care)/485 Worksheet CM-3 dated 5/13/14 completed by registered nurse (RN), Employee G, indicated both the Full code and Do not resuscitate had been marked. At a later date the Do not resuscitate had been errored out by Employee G. A date was not present on the error out. B. The physician orders for the certification period 5/16/14 through 7/14/14 states, "CODE STATUS: Do not resuscitate." The principal diagnosis is Dysphagia and orophargnyeal. C. The Home Health Aide Assignment Sheet dated 3/17/14 and 5/13/14 does not have a place to mark a whether the patient is to be resuscitated, leaving the aide to make their own decision. D. On 5/13/14 at 5:30 PM, the licensed speech therapist (ST), Employee I, evaluated the patient and re-certified the patient because "Patient demonstrates			

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	severe oropharyngeal dysphasia resulting in NPO (nothing by mouth) status. " E. On 6/13/14 at 11:10 AM, Alternate Director of Nursing, Employee F, indicated a coding error had been made that put a Do Not Resuscitate on the 485/Plan of Care. The software company picked up the Do Not Resuscitate coding. The physician signed the POC/485 as a Do Not Resuscitate. The patient is really a full code. Staff have been going to the home from 5/16/14 till today (6/13/14) under the impression the patient was a Do Not Resuscitate. F. The undated policy titled "Do Not Resuscitate Status" stated, "A written DNR order will be issued by the patient's primary physician (if DNR order originated during the patient's hospital stay, a new order must be obtained for use by the home health agency)." 2. Clinical record 6 evidenced a prescription written by an orthopedic physician and dated 5/13/14. The prescription ordered Lovanox [short term use anticoagulant to prevent clotting] 40 milligrams subcutaneous for 10 days, "post op [after surgery] ... P.T [physical therapy]: Strict TTWB [toe touch weight bearing] left lower extremity, hip			

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	precautions, if not complainant with weight bearing restriction, bed to chair transfers only, daily dressing changes, left hip with foam tape." A. The record included a plan of care for the certification period 5/15/14 through 7/13/14, start of care 5/15/14, contained two signatures on the plan of care name of the attending listed on the plan of care and the name of the nurse practitioner whom signed the plan of care. The plan of care failed to include the directions received from the orthopedic physician and the lovenox. B. A telephone interview with a representative of the clinic on 6/13/14 at 12:15 PM indicated the nurse practitioner, employee R, signed the patient's plan of care and the physician listed on the plan of care had never examined the patient. The physician listed was the medical director for the Indiana Health Center in Kokomo and the patient was only seen in the clinic by the nurse practitioner. 1. Clinical record # 1, start of care 5/23/14, included a medical plan of care for the certification period 5/23/14 to 7/21/14 with orders for physical therapy (P.T.) to evaluate and treat by week 2 of the certification period. The clinical			

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	record evidenced the P.T. evaluation was completed on 5/28/14 and treatments were provided on 6/3/14 and 6/6/14. The clinical record failed to evidence specific physician orders for the treatments or modalities to be used and the length of treatment. 2. Clinical record 6 evidenced a prescription, written by an orthopedic physician and dated 5/13/14, that ordered Lovenox [short term use, subcutaneous injectable anticoagulant to prevent clotting] 40 milligrams subcutaneous for 10 days, "post op [after surgery] ... P.T.: Strict TTWB [toe touch weight bearing] left lower extremity, hip precautions, if not complainant with weight bearing restriction, bed to chair transfers only, daily dressing changes, left hip with foam tape." The record evidenced the physical therapist completed the evaluation on 5/23/14 and treatments were provided on May 23, 27, and 29 and June 3 and 5, 2014. The clinical record failed to evidence physician orders for the treatments or modalities to be used and the length of treatment.			
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			

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	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 as ordered on the plan of care in 3 of 12 clinical records reviewed (1, 5, and 12) with the potential to effect all patients receiving nursing services. Findings: 1. Clinical record 12, start of care 5/19/14, failed to evidence a plan of care signed by the physician at the time of the survey on 6/13/14. A verbal order was obtained 5/19/14 for Home care evaluation and treat skilled nurse 2 times a week times 1 week, physical therapy evaluation and treat and occupational therapy evaluation and treat. The physician signed the verbal order 5/27/14. The clinical record evidenced skilled nurse visits without orders week 3 on 5/29/14 and week 4 on 6/2/14. 2. The undated policy titled "Medication Administration Guidelines" number 2.57 stated, "Antibiotics a. Nurses are only permitted to give the initial dose in the home with knowledge of the physician and specific orders for treatment of a reaction are provided by the physician. ... The nurse should observe the patient /	N000537	G170/N537-100 % of charts will be audited by DON, ADON or QI manager related to MD orders and POC orders/modifications/additions by July 11, 14. Staff was given a plan of correction inservice notice that instructed them on contacting the MD with POC orders/modifications/additions. The disciplines were also told verbally of this need. Disciplines will ensure that they perform care under the MD order. Staff will be educated per plan of correction inservice notice on consulting with the MD for every aspect of care to be provided and that care cannot deviate from a current order for Tx or meds. A new order must be obtained for any change. The MD will be contacted for all initial and ongoing treatment orders. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	07/13/2014

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	client for any reaction for at least 30 minutes after the dose is given. ... Document medication administration by charting it in the patient / client's clinical record, to include: a. medication name, dose, route, ... c. medication date and time. ... Observe the patient / client for medication results and document, ... 1. Verify the physician order for medication administration. 2. Verify the date and time of the last medication administration by checking the documentation in the patient / client record." 3. Clinical record 1, start of care (SOC), evidenced a plan of care for the certification period 5/23/14 through 6/11/14 with orders for skilled nurse once a week for eight weeks. Employee B signed the plan of care dated 5/21/14 indicating a verbal order was received for these orders on 5/21/14. The record failed to evidence the verbal order referenced. The record included a two page referral dated 5/21/14 which was signed by employee B. The referral did not include a verbal order as written on the plan of care. A. A physician order dated 5/23/14, written by employee K, indicated a verbal order was obtained from the attending physician for home health care evaluate and treat, skilled			

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	nurse one visit during week one. B. The record evidenced the occupational therapist completed an assessment on 5/31/14 and completed additional visits on June 2 and June 4, 2014. The record failed to evidence a physicians order for the occupational visits and the services provided. 4. Clinical record 5, start of care 4/16/14, included a medical plan of care for the certification period 4/16/14 through 6/16/14 with orders for skilled nursing to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a week for 7 weeks to assess / evaluate all body systems, wound care - right inner buttock, cleanse with normal saline, apply alginate and cover with mepilex daily, and wound care - left inner buttock - cleanse with normal saline, apply black sponge and wound vacuum at 125 mmHg, change every 3 days. The plan of care included an IV medication order for zosyn 2.25 milligrams to be administered every 8 hours for six days. The record failed to evidence a physician was consulted for wound treatment orders and the IV antibiotic orders as written on the plan of care. A. Skilled nurse visit note dated			

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	4/17/14 completed by employee P, a licensed practical nurse stated, "IV ATB [antibiotic] ran per order ... PICC flushes." Employee C completed a skilled nurse visit at the same time and documented the Wound Visit Note Addendum which identified the left wound was with tunneling or undermining, was not specific which, 6.0 centimeters at 11 o ' clock, tunneling and / or undermining which was not documented on the comprehensive assessment, and documentation the left wound was dressed with green foam verse the black foam as written on the plan of care prior to applying the wound vacuum. The visit note and clinical record failed to evidence the physician was notified about the tunneling / undermining and the record failed to evidence a physician order for green foam to be used with the wound vacuum. The visit note and clinical record failed to evidence patient / caregiver education, measurement of learning, observation of caregiver / patient technique for the PICC care, IV administration, wound care procedures for level of education, any deficits and education needs, and a clear delineation which tasks the patient / caregiver was competent to complete. B. Skilled nurse visit note dated 4/18/14 completed by employee C, a RN,			

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	indicated a blood draw was obtained from the PICC and the PICC line was flushed and locked with Heparin. The visit note failed to evidence who administered the IV medications, failed to include a wound assessment, failed to evidence a body systems assessment, a line was drawn through 50 % of the visit note and the systems assessment portion was left blank. C. Skilled nurse visit note dated 4/19/14 completed by employee C stated, "Removed green foam dressing, cleansed with normal saline, filled with green foam." The documentation failed to evidence an assessment of the PICC line, an assessment of the right wound, and an assessment of all body systems - the portion of the nurse visit note was left blank. D. Skilled nurse visit note dated 4/21/14 completed by employee C failed to evidence an assessment of the patient's body systems, the portion of the note was blank with a line drawn through, failed to evidence an assessment of the PICC access, and failed to assess the wound on the patient's right buttock The note indicated the dressing to the wound on the left buttock was changed and wound vacuum was attached. The visit note failed to evidence the laboratory draw			

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	was obtained as written on the plan of care. E. Skilled nurse visit note dated 4/22/14 completed by employee C addressed only the wound on the left and indicated the wound was tunneling or undermined [not specified] at 11 o ' clock. The documentation evidenced the nurse changed to wound dressing, applied green foam to the wound bed, and reattached the wound vacuum. F. Skilled nurse visit note dated 4/23/14, completed by employee P, that documented the wounds were not assessed during the visit and stated, "Assisted patient with IV ATB [antibiotics]." The plan of care indicated the antibiotic zosyn was ordered for 6 days beginning 4/16/14. The record failed to explain why the patient was infusing the antibiotic on the 7th day following the start of the antibiotic. G. Skilled nurse visit note dated 4/24/14, completed by employee P, failed to evidence care was provided to the wound on the right and an assessment of either wound. Only the wound on the left was addressed within the notes - noted the dressing was changed. H. Skilled nurse visit note dated			

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	4/25/14, completed by employee P, failed to evidence care was provided to the wound on the right and an assessment of either wound; only the wound on the left was addressed within the notes which noted the dressing was changed. I. Skilled nurse visit note dated 4/29/14, completed by employee P, evidenced the wound on the right buttock was healed and the wound on the left was now 17.0 centimeters in length X 4.0 cm width, no depth was documented and undermining / tunneling [not specified] was measured to be 6.0 cm at 11 o'clock, and a blood serum sample was collected from the PICC. The employee documented the wound on the left was packed with green foam and not the black foam as written on the plan of care. J. Skilled nurse visit note dated 5/1/14, completed by employee P, indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care. K. Skilled nurse visit note dated 5/3/14, completed by employee P and indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care.			

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	L. Skilled nurse visit note dated 5/7/14, completed by employee C stated, "Patient released from overnight stay at hospital 5/6/14 to have abscess I & D [incision and drainage]. New wound and IV antibiotics." Documentation evidenced the wound on the left buttock was 14.0 cm length X 3.5 cm width X 0.3 cm depth and the wound on the right was 3.0 cm width X 1.5 cm length X 1.75 cm depth. The record included a Physician Order from Walgreens Infusion that listed the medication "Invanz 1 gram / 100 mL NS [normal saline] Mini Bag Plus" and the instructions were to "Activate bag as directed prior to each dose to dissolve completely, then infuse Invanz 1 GM / 100 mL over 1 hour (100 mL / hr) once every 24 hours per PICC line via gravity set X 7 days." The documentation for the skilled nurse visit failed to evidence a full body systems assessment and an assessment of the PICC line was completed during the visit. The note stated, "Instructed on new antibiotic." The record failed to evidence orders for the new wound beds or that the attending physician was consulted regarding the new IV antibiotic orders and wound care. M. Skilled nurse visit note dated 5/8/14 indicated the wound of the left buttock was cleansed and green foam was			

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	applied to the wound bed and vacuum applied. The wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. N. Skilled nurse visit note dated 5/10/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied. The wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. O. The record failed to evidence the PICC access dressing was changed during week four of the certification period. Skilled nurse visits were completed on May 7, 8, and 10, 2014 . The documentation from these visits failed to evidence an assessment of the PICC access and a dressing change. The record failed to evidence an order to disregard the plan of care order for weekly dressing changes to the PICC access. 6. On 6/12/14 at 2:08 PM, employee A indicated, when asked, the referral is obtained from the office nurse and that each discipline was to write the name of			

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	the attending on the assessment which was to prove they contacted the attending physician for treatment orders. 7. On 6/12/14 at 1:15 PM, employee O indicated he / she only places the name of the attending on the form but he does not contact the physician for treatment orders and that the office staff obtained the treatment orders. When asked to clarify, employee O indicated he / she was referring to the initial order obtained for the evaluation of the patient. 8. During a face to face interview on 6/13/14 at 10:00 AM, employee M, indicated he / she completed comprehensive assessments and admitted patients for home health services. He / she indicated the office staff obtain the orders and the nurse in the field does not call for physician orders to treat the patient unless there was a concern or question. He/ she indicated when the clinician writes the name of the attending physician on the assessment document it is only referring to the initial order to evaluate the patient for home health services and is not indicating the disciple contacted the physician for treatment orders and for input in the development of the plan of care. 9. During a telephone interview on			

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	6/13/14 at 12:30 PM, employee N indicated the initial physician order to evaluate for home health services was completed by office nurse named employee F. When asked if he / she calls the physician for initial treatment orders, employee N indicated he / she does not call the physician for treatment orders after completing the comprehensive assessment. He / she indicated the plan of care is written and sent to the physician and if the physician wishes to change the orders then they may at that time.			
N000541	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on clinical record review and observation, the agency failed to ensure the registered identified and addressed safety concerns in the patients home in 1 of 6 home visits observed (#1) creating	N000541	G172/N541-100 % of active charts will be reviewed by DON, ADON, or QI Manager to ensure that no safety issue is present in current charts. Education to pt/family/caregiver on safety is to be completed by skilled	07/13/2014

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	the potential for the patient to fall and harm themselves. The findings include: 1. On 6/11/14 at 4:30 PM, patient 1 was observed in the home. The patient lives alone in a ranch style home with private paid help during the day. The home visit was for physical therapy. The patient indicated the patient had fallen off the toilet extension earlier in the day. The connector to the toilet extension had given loose from the toilet and the extension had fallen to one side. The paid attendant had caught the patient before hitting the floor. The patient did not appear to be hurt. The paid attendant had not notified anyone. The patient had called a friend to come and put on different handles on the toilet. The handles attached directly to the back of the toilet through the lid holes. Upon inspection, both the new handles and the toilet extension are loose and tilt from side to side. The agency nurse stayed in the living room and did not come to the bathroom for the toilet inspection. The physical therapist assistant did come in. On 6/11/14 at 5:15 PM, the physical therapist assistant, Employee J, indicated the new bars and the toilet extension were not securely attached to the toilet.		staff. Staff will be instructed to record safety issues on comprehensive assessment or visit note and will be re-instructed on the incident reporting policy. The DON and/or ADON will instruct the clinical staff on safety issue/incident reporting. The agency will ensure all pts are regularly evaluated and re-evaluated following any incident regarding pt safety, or any health concern. When the agency is aware of a safety concern or incident, an incident report is completed which includes notifying the MD of the incident. Staff are instructed to complete the incident report and notify the MD. Disciplines ongoing safety assessment is to be addressed on each visit. Ongoing chart audits are reviewed with quarterly record review by the QI manager. This will be completed by July 13, 14.	

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	When the patient would try to get up and put more weight on one side than the other, they would tilt. 2. Clinical record 1, start of care (SOC) evidenced a plan of care for the certification period 5/23/14 through 6/11/14 with orders for skilled nurse once a week for eight weeks, physical therapy to evaluate and treat, and occupational therapy to evaluate and treat by the second week. The record failed to identify the lack of safety features in the patient's bathroom and that a plan had been developed to prevent and reduce falls. The comprehensive assessment evidenced the patient was assessed to be at risk for falls with a score of 11. Greater than 10 was determined by the facility assessment form to be at high risk for falls.			
N000542	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.			

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	Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse initiated an accurate plan of care in 2 of 12 records reviewed with the potential for patient harm for this patient and the ability to affect all the patients. (5 and 10) Findings: 1. Clinical record 10 evidenced physician orders for the certification period 3/17/14 through 5/15/14. The physician orders did not evidence a Do Not Resuscitate order. The principal diagnosis listed is Attention to Gastrostomy. The plan of care indicated the patient was a Do Not Resuscitate status. A. A 2010 Smart Scribe Medical POC (Plan of Care)/485 Worksheet CM-3 dated 5/13/14 completed by registered nurse (RN), Employee G, indicated both the Full code and Do not resuscitate had been marked. At a later date the Do not resuscitate had been errored out by Employee G. A date was not present on the error out. B. The physician orders for the certification period 5/16/14 through 7/14/14 evidences "CODE STATUS: Do not resuscitate."	N000542	G173/N542-100% of all active patients were reviewed by the QI manager. A process was developed and each active chart was reviewed to ensure the DNR status was correct. An active patient list was compiled to track the audit and ensure correct code status. Any chart found that did not have correct DNR/Code status was corrected by writing an MD order of clarification. A list was compiled to track the audit and ensure correct code status. This has been completed as of July 7, 14. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	07/13/2014

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	C. The Home Health Aide Assignment Sheet dated 3/17/14 and 5/13/14 does not have a place to mark a resuscitation code, leaving the aide to make their own decision. D. On 6/13/14 at 11:10 AM, Alternate Director of Nursing, Employee F, indicated a coding error had been made that put a Do Not Resuscitate on the 485/Plan of Care. The software company picked up the Do Not Resuscitate coding. The physician signed the POC/485 as a Do Not Resuscitate. The patient is really a full code. Staff have been going to the home from 5/16/14 till today (6/13/14) under the impression the patient was a Do Not Resuscitate. E. The undated policy titled "Do Not Resuscitate Status" stated, "A written DNR order will be issued by the patient's primary physician (if DNR order originated during the patient's hospital stay, a new order must be obtained for use by the home health agency)." 2. Clinical record 5, start of care 4/16/14, included a medical plan of care for the certification period 4/16/14 through 6/16/14 with orders for skilled nursing to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day for 3 days			

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	a week for 7 weeks to assess / evaluate all body systems, wound care - right inner buttock, cleanse with normal saline apply alginate and cover with mepilex daily, wound care - left inner buttock - cleanse with normal saline apply black sponge and wound vacuum at 125 mmHg and change every 3 days. The plan of care included an IV medication order zosyn 2.25 milligrams to be administered every 8 hours for six days. The record included a physician order dated 4/16/14 for home health evaluate and treat, written by employee K at 4:30 PM. The record failed to evidence a physician was consulted for the wound treatment orders and the IV antibiotic orders as written on the plan of care. A. On a document titled "MCD [Medicaid] Skilled Care Plan / Nursing Visit Note" of the same date, 4/16/14, stated, "Discharge from acute hosp [hospital] with ongoing extensive wound care needs including cont. [continuous] IV [intravenous] therapy - both requiring SN." The documentation indicated the plan was for the skilled nurse to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a week for 7 weeks; wound care per wound vacuum, to be changed every 3 days; a laboratory draw, a basic metabolic profile on 4/18/14, 4/21/14, and 4/23/14; and to			

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	maintain PICC per protocol with sterile dressing change every 7 days. The record failed to evidence a physician was consulted and orders received for the plan as written by the RN which included physician order for the IV antibiotics, wound care orders, and orders for follow through on the low hemoglobin and potassium as noted on the comprehensive assessment. B. Skilled nurse visit notes dated 5/1/14 and 5/3/14 completed by employee P indicated a dressing change to the wound on the left was completed and green foam was placed in the wound bed, not the black foam as written on the plan of care. The record failed to evidence a change to the plan of care. C. Skilled nurse visit note dated 5/7/14 completed by employee C stated, "Patient released from overnight stay at hospital 5/6/14 to have abscess I & D [incision and drainage]. New wound and IV antibiotics." Documentation evidenced the wound on the left buttock was 14.0 cm length X 3.5 cm width X 0.3 cm depth and the wound on the right was 3.0 cm width X 1.5 cm length X 1.75 cm depth. The record included a Physician Order from Walgreens Infusion that listed the medication "Invanz 1 gram / 100 mL NS [normal saline] Mini Bag Plus" and			

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	the instructions "Activate bag as directed prior to each dose to dissolve completely, then infuse Invanz 1 GM / 100 mL over 1 hour (100 mL / hr) once every 24 hours per PICC line via gravity set X 7 days." The record failed to evidence physician orders for the new wound beds and that the attending physician was consulted regarding the new IV antibiotic orders and wound care. D. Skilled nurse visit note dated 5/8/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied and that the wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. E. Skilled nurse visit note dated 5/10/14 indicated the wound of the left buttock was cleansed and green foam was applied to the wound bed and vacuum applied and that the wound on the right buttock was cleansed with normal saline and a wet to dry dressing was applied. The record failed to evidence a physician order for the wound care provided. F. During a face to face interview on 6/13/14 at 10:00 AM, employee M, indicated he / she completed			

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	157631	A. BUILDING 00 B. WING	06/13/2014

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	comprehensive assessments and admitted patients for home health services. He / she indicated the office staff obtain the orders and the nurse in the field does not call for physician orders to treat the patient unless there was a concern or question. He/ she indicated when the clinician writes the name of the attending physician on the assessment document it is only referring to the initial order to evaluate the patient for home health services and is not indicating that the disciple contacted the physician for treatment orders and for input in the development of the plan of care. G. During a telephone interview on 6/13/14 at 12:19 PM, employee N indicated the initial physician order to evaluate for home health services was completed by office nurse and named employee F. When asked if he / she calls the physician for initial treatment orders, employee N indicated that he / she does not call the physician for treatment orders after completing the comprehensive assessment. He / she indicated the plan of care is written and sent to the physician and if the physician wishes to change the orders then they may at that time.			
N000543	410 IAC 17-14-1(a)(1)(D)			

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	Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse accurately initiated the "Do Not Resuscitate" status of the 1 of 6 home visit patients (10) with the potential for patient harm for this patient and the ability to affect all the patients with advance directives. Findings: 1. Clinical record 10 evidenced physician orders for the certification period 3/17/14 through 5/15/14. The physician orders did not evidence a "Do Not Resuscitate" order. The principal diagnosis listed was Attention to Gastrostomy. 2. A 2010 Smart Scribe Medical POC (Plan of Care)/485 Worksheet CM-3 dated 5/13/14 completed by registered nurse (RN), Employee G, indicated both the Full code and Do not resuscitate had been marked. At a later date the Do not resuscitate had been errored out by Employee G. A date was not present on	N000543	G175/N543-100% of all active patients were reviewed by the QI manager. A process was developed and each active chart was reviewed to ensure the DNR status was correct. An active patient list was compiled to track the audit and ensure correct code status. Any chart found that did not have correct DNR/Code status was corrected by writing an MD order of clarification. A list was compiled to track the audit and ensure correct code status. This has been completed as of July 7, 14. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present to meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficiency and the corrective actions are completed by July 13, 14.	06/13/2014

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	the error out. 3. The physician orders for the certification period 5/16/14 through 7/14/14 states, "CODE STATUS: Do not resuscitate." The principal diagnosis is Dysphagia and orophargnyeal. 4. The Home Health Aide Assignment Sheet dated 3/17/14 and 5/13/14 does not have a place to mark a whether the patient is to be resuscitated, leaving the aide to make their own decision. 5. On 5/13/14 at 5:30 PM, the licensed speech therapist (ST), Employee I, evaluated the patient and re-certified the patient because "Patient demonstrates severe oropharyngeal dysphasia resulting in NPO (nothing by mouth) status. " 6. On 6/13/14 at 11:10 AM, Alternate Director of Nursing, Employee F, indicated a coding error had been made that put a Do Not Resuscitate on the 485/Plan of Care. The software company picked up the Do Not Resuscitate coding. The physician signed the POC/485 as a Do Not Resuscitate. The patient is really a full code. Staff have been going to the home from 5/16/14 till today (6/13/14) under the impression the patient was a Do Not Resuscitate.			

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	7. The undated policy titled "Do Not Resuscitate Status" stated, "A written DNR order will be issued by the patient's primary physician (if DNR order originated during the patient's hospital stay, a new order must be obtained for use by the home health agency)."			
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 and policy review and interview, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days as required by agency policy in 1 of 6 records reviewed of patients who received skilled and home health aide services longer than 14 days (# 6). Findings include: 1. The undated agency policy titled	N000606	The DON and ADON will educate staff regarding aide supervision 484.36dB. The QI manager will audit 20% of new and current charts monthly for the next year to ensure supervisory visits are made by RN In accordance with the regulations. The DON, ADON and QI manager will be responsible for monitoring these corrective actions for compliance. The deficiency will be corrected by July 13, 14.	07/13/2014

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	"Home Health Aide Supervisory Visits" number 2.49 stated, "When a patient / client is receiving skilled services, a home health care RN or therapist will make a supervisory visit to the patient's / client's residence at least every 14 days." 2. Clinical record 6 included a verbal order written by employee N dated 5/15/14 stated, "Home Health Care Services, skilled nurse Q O W [every other week] HHA 1-3 h 3 d w 1 [home health aide one to three hours a day three days a week for one week.] PT Eval [physical therapy evaluation] and Treat." Home health aide visit notes evidenced aides services were provided by employee Q, HHA, 4 hours a day from May 15 through 31, 2014. The record evidenced the physical therapist completed the evaluation on 5/23/14 and treatments were provided on May 23, 27, and 29 and June 3 and 5, 2014. The clinical record failed to evidence the physical therapist or a skilled nurse conducted a supervisory visit at least every 14 days. 3. On June 12, 2014, at 5:10 PM, employee A indicated there was no further information to evidence for this record.			