

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157483	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2019
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NAME OF PROVIDER OR SUPPLIER FRIENDS HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 N 15TH ST VINCENNES, IN 47591
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E 0000 Bldg. 00	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.62. A fully extended survey was announced 1/7/19.</p> <p>Survey Date: January 2, 3, 4, and 7 of 2019</p> <p>Facility Number: IN009488 Provider Number: 157483</p> <p>Census = 12</p> <p>At this Emergency Preparedness survey, Friends Home Health Care Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 494.62.</p>	E 0000		
E 0039 Bldg. 00	<p>Based on record review and interview, the agency failed to ensure that all employees participated in the table top exercise to test their emergency plan for 1 of 1 agency.</p> <p>Findings include:</p> <p>A review of the Emergency Preparedness program set forth in writing failed to evidence that a tabletop exercise for all staff, contractors, and agency volunteers was conducted in order to ensure all individuals are aware of the emergency preparedness program.</p>	E 0039	<p>The agency ordered an emergency preparedness manual that has detailed information in it on how to conduct ongoing emergency preparedness. The agency is implementing the policies in to our yearly plans. The agency has a recent facility based table top exercise based on the impending snow storm.</p> <p>All staff will be included in all tabletop or full scale exercises. The administrator will include the emergency preparedness exercises in the QAPI evaluation</p>	01/25/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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G 0000 Bldg. 00	<p>During an interview on 1/7/19 at 1:30 p.m. the Alternate Administrator, who was listed as the second-in-command for the emergency preparedness program, was asked to provide documentation that a tabletop exercise was conducted and that would demonstrate how the tabletop exercise addressed any risk(s) in the agency's risk assessment, communicated potential needs to local agencies, and provided medical information to support the patients' continuity of care, as well as identified lessons learned following the tabletop exercise. The Alternate Administrator stated the agency only conducted a tabletop exercise to office staff and did not conduct a tabletop exercise to the field staff.</p> <p>This was a Federal home health recertification survey. Partial extended January 4, 2019 Fully Extended January 7, 2019</p> <p>Survey Dates: January 2, 3, 4, and 7, 2019</p> <p>Facility #: 009488 Medicare Provider #: 157483 Medicaid Vendor #: 200198250</p> <p>Census: 12</p> <p>Friends Home Health Care is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 01/07/19 to 01/07/21, for being out of compliance with Condition of Participation 42 CFR 484.75 Skilled professional services.</p>	G 0000	yearly to ensure the exercises have been done.	

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G 0436 Bldg. 00	<p>Based on record review and interview the agency failed to ensure care and services were provided per the plan of care for 2 of 7 records reviewed. (Patient 1, 2)</p> <p>Findings include:</p> <p>1. A policy, revised 2015, and titled, "Plan of Care - CMS #485 and Physician's Orders," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Newly identified patient's medical, nursing, and rehabilitative needs are addressed in updates to the Plan of Care. Care and services will be provided according to physicians orders. Orders are current and updated. If the agency provides fewer visits than the physician orders, it has altered the plan of care and the physician must be notified. The Agency must maintain documentation in the clinical record indicating that the physician was notified and is aware of the missed visit."</p> <p>2. During a record review on 1/2/19 at 1:55 p.m., Patient 1's most recent 485 (plan of care) order for the certification period of 11/10/2018-01/08/2019 indicated an order for SN (skilled nurse) 8 (eight) hrs (hours) daily 3 -5 XWX9W (three to five times per week times 9 weeks).</p> <p>Patient 1's Nursing Visit Records were reviewed and indicated the following:</p> <p>A skilled nurse visit by Employee G on 11/14/18 from 7:30 a.m. to 2:30 p.m. which indicated a visit of 7 (seven) hours. Employee G indicated Patient</p>	G 0436	<p>We have ensured the proper amount of time is now scheduled and matches what is ordered by the physician.</p> <p>Closer attention will be paid to client schedule changes and the physician will be notified of any changes. The staff was in-serviced on when to notify office of schedule changes so the Dr. can be informed.</p> <p>The administrator is responsible for in-servicing staff and delegating who and when to make phone calls. The Director of clinical services will review charts weekly to ensure patients receive proper amounts of time and that physicians have been notified if necessary.</p>	01/21/2019

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	<p>1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A skilled nurse visit by Employee G on 11/15/18 from 9:30 a.m. to 4:30 p.m. which indicated a visit of 7 hours. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A communication note written by Employee D on 12/21/18 indicated Patient 1's family member called to report they would be on vacation until 12/28/18 and would not need visits. The clinical record lacked documentation of physician notification of missed visits and a written order.</p> <p>A skilled nurse visit by Employee G on 11/28/18 from 7:30 a.m. to 2:30 p.m. which indicated a visit of 7 hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A skilled nurse visit by Employee G on 12/5/18 from 7:30 a.m. to 2:30 p.m. which indicated a visit of 7 hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A skilled nurse visit by Employee G on 12/12/18 from 7:30 to 2:30 p.m. which indicated a visit of 7 hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>3. During an interview on 1/2/19 at 3:22 p.m., the Administrator indicated a communication note</p>			

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G 0546 Bldg. 00	<p>and physician notification should occur with missed visits.</p> <p>4. During an interview on 1/3/19 at 1:59 p.m., Employee D indicated according to Patient 1's current orders, the nurse should be in the home for 8 hours. 5. The clinical record for Patient 2, certification period 12/11/18 to 2/8/19, start of care 11/3/14, was reviewed on 1/2/19. The Plan of Care included orders for home health aide services for 10 hour days times 7 days a week. The record failed to evidence home health aide visits were conducted for the full 10 hours on the following dates: 11/22, 11/26, 12/4, 12/11, 12/18, 12/24, and 12/25 of 2018.</p> <p>During an interview on 1/4/19 at 3:00 p.m. the Administrator acknowledged the home health aide visits were not conducted according to the physician's order.</p> <p>Based on record review and interview, the facility failed to ensure an RN (Registered Nurse) performed a recertification visit in the home for 1 of 1 patients with routine LPN (Licensed Practical Nurse) visits. (Patient 1)</p> <p>Findings include:</p> <p>A policy, revised 2014, and titled, "Nursing Services," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Professional nursing services will be provided by a registered nurse and include: Initial and ongoing comprehensive assessments of the patient's needs, including Outcome and</p>	G 0546	<p>There will be an onsite visit for OASIS and data collection by an RN in the last 5 days of the certification period, unless there is a beneficiary elected transfer, significant change in condition, or discharge and return to the same HHA during the 60-day episode or the patient or representative refuses the visit.</p> <p>The scheduler will keep a a calendar of all re-certifications and discharges and will put these on the RN weekly schedule of visits to be made.</p> <p>The admin will in-service the</p>	01/17/2019	

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	<p>Assessment Information Set (OASIS) assessments at appropriate points; Initiating the plan of care and revising as necessary; Providing those services and/or treatments requiring substantial and specialized nursing skill; Counseling and educating the patient and family regarding the disease process, self-care techniques, and prevention strategies; Evaluating the effectiveness and outcomes of care; Supervising LVN/LP Ns and paraprofessionals providing services."</p> <p>During a record review on 1/2/19 at 1:55 p.m., Patient 1's record indicated a recertification visit on 11/8/18 with time in and time out listed as "-NA-" (not applicable). The recertification visit note was not signed by any staff member.</p> <p>Patient 1's Medication Profile indicated a medication reconciliation was completed by Employee D on 11/8/18.</p> <p>During an interview on 1/3/19 at 11:25 a.m., Employee G (an LPN - Licensed Practical Nurse) indicated she would see Patient 1 every Monday through Friday for eight hours per day. Employee G indicated recertification visits were completed by Employee B (an RN) but Employee B did not see Patient 1 in the home.</p> <p>During an interview on 1/3/19 at 1:59 p.m., Employee D indicated recertifications visits for Patient 1 were completed by Employee D or the Administrator (both RN's), but they did not go into the home to complete since a skilled nurse was already in the home. Employee D indicated they would speak with the LPN on the phone for information regarding the patient.</p> <p>During an interview on 1/3/19 at 2:34 p.m.,</p>		<p>scheduler and the RN's. The director of clinical services will review charts weekly to ensure all OASIS data sets are done in the proper time frame.</p>	

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G 0576 Bldg. 00	<p>Employee D indicated an RN would only go to see Patient 1 if needed.</p> <p>Based on record review and interview the agency failed to record verbal orders in the plan of care of patients receiving physical therapy services in 1 of 1 records reviewed (Patient 3).</p> <p>Findings include:</p> <p>A policy titled Plan of Care - CMS #485 and Physician Orders was provided by the Alternate Administrator on 1/3/19 at 11:30 a.m. The policy indicated but was not limited to "Newly identified patient's medical, nursing and rehabilitative needs are addressed in updates to the Plan of Care."</p> <p>The clinical record for Patient 3, certification period 8/10/18 to 10/8/18, start of care date 8/10/18, included a physician order for "PT to consult eval [evaluate] and treat" in the Plan of Care.</p> <p>A Physical Therapy Treatment Plan record evidenced a frequency and duration for "Eval +2, 3x4, 2x1". The agency failed to update the Plan of Care to include the frequency and duration for Physical Therapy.</p> <p>During an interview on 1/4/19 at 3 p.m. the Administrator stated she was not aware that verbal orders needed to be recorded in the plan of care.</p>	G 0576	<p>All 485 will be updated with the PT frequency and duration upon receiving it.</p> <p>The director of clinical services will review charts weekly to ensure all PT frequency and duration orders are on the 485 updates.</p> <p>The admin will in-service office staff on this change.</p>	01/14/2019
G 0590				

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Bldg. 00	<p>Based on record review and interview, the agency failed to ensure the physician was notified of changes in a patients skin integrity in 1 of 1 patients with skin impairment issues out of a total of 7 records reviewed. (Patient 7)</p> <p>Findings include:</p> <p>A policy titled Nursing Services was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated but was not limited to "Informing the physician and other staff of changes in the patient's needs"</p> <p>The clinical record for Patient 7, start of care 3/25/18, was reviewed on 1/3/19, and contained a plan of care for the certification period of 9/21/18 to 11/19/18, with wound orders for the skilled nursing to provide treatment to the patient wounds.</p> <p>Review of a skilled nursing visit notes from 9/21/18 to 10/7/18 indicated the wound was intact. On 10/8/18, the skilled nursing visit note indicated the patient had an open area on the right buttock that measured 1 x 1 centimeters. On 10/10 and 10/11/18, the skilled nursing visit notes indicated the patient had an open area to the left buttock that measured 1 x 1 centimeters. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>Review of a skilled nursing visit note dated 9/27/18, indicated the patient's pressure ulcers on the buttocks was red and surround tissue was dark pink. On 9/28/18, the skilled nursing visit note indicated the wounds were dark red and</p>	G 0590	<p>Physician was immediately notified of resolution of wounds on the patient.</p> <p>The RN will notify the physician and other appropriate medical personnel of any changes immediately after or during client visit.</p> <p>The director of clinical services will review nursing notes weekly to ensure all notifications have been made.</p>	01/17/2019	

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G 0606 Bldg. 00	<p>surrounding tissue was dark pink. On 10/5 and 10/8/18 the skilled nursing visit note indicated the wounds were red and purple. On 10/9/18, the skilled nursing visit note indicated the wounds were very red and dark purple. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>Review of a skilled nursing visit note dated 10/12/18, indicated the patient's pressure ulcers on the buttocks were blanchable. On 10/19/18, the skilled nursing visit note indicated the patient's pressure ulcers was non-blanchable. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>During an interview on 1/4/19 at 10:10 a.m., the Administrator stated the agency did not routinely call the physician with changes to color such as from red to purple.</p> <p>Based on record review and interview, the facility failed to ensure an coordination of care between staff members were documented in the clinical record in 2 of 2 clinical records reviewed with more than one certification period (Patient 1 and 4)</p> <p>Findings include:</p> <p>1. A policy, revised 2014, and titled, "Coordination of Patient Care," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Case conferences are held on an ongoing basis to discuss any new admissions, patients to be</p>	G 0606	Case Conferences will be held weekly and any time there is a change. These will be documented in patient charts. The director of clinical services will review charts weekly to ensure case conference documentation is in the patient charts. Administrator will in-service staff on coordination of patient care policy.	02/01/2019	

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G 0608 Bldg. 00	<p>recertified within the next 30 days and any problems. Documentation of case conferences will be maintained in the patient's medical record."</p> <p>2. During a record review on 1/2/19 at 1:55 p.m., Patient 1's clinical record indicated a start of care date of 7/18/17. Patient 1's clinical record lacked documentation of an interdisciplinary case conference to discuss recertifications.</p> <p>3. During a record review on 1/4/19 at 11:29 a.m., Patient 4's clinical record indicated a start of care date of 10/17/18. Patient 4's clinical record lacked documentation of an interdisciplinary case conference to discuss recertification or discharge.</p> <p>During an interview on 1/2/18 at 3:05 p.m., Employee D indicated any notes on conferencing would be at the bottom of the nursing visit records and there was no formal case conference. Employee D stated two nurses in the office would discuss recertification and/or discharge. Employee D indicated the discussions were not written down anywhere and there were no case conference notes.</p> <p>Based on record review and interview the agency failed to follow agency policy on coordination of patient care with other providers for 1 of 2 patients that receive care from other providers. (Patient 2)</p> <p>Findings include:</p> <p>A policy titled Coordination of Patient Care was provided by the Administrator on 1/4/19 at 1:30</p>	G 0608	We will coordinate care with external organizations at least every 60 days when doing an oasis visit or when significant changes occur and relevant information needs to be shared. The director of clinical services will review all oasis visits to ensure they include a case conference will all pertinent external organizations.	02/01/2019	

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G 0610 Bldg. 00	<p>p.m. The policy indicated but was not limited to "Care will be coordinated with other involved external organizations, e.g., home medical equipment providers, infusion therapy/pharmacy companies and community agencies. Staff will: Understand Agency and organization's responsibilities in providing care or services. Communicate with other individuals or organizations involved in the patient's care when significant changes occur in the patient's overall care. Share relevant information to facilitate appropriate continuity and care coordination."</p> <p>On 1/7/19 at 11 a.m. reviewed the clinical record for Patient 2, certification period 12/11/18 to 2/8/19, start of care date 11/3/14. The clinical record included orders for attendant care services 3.5 hours per day for 7 days a week to be provided by another agency. The clinical record included documentation that Coordination of Care took place on 3/2/16 with the attendant care provider, and indicated that 4.5 hours per day of attendant care services were to be provided. The record failed to evidence that any Coordination of Care with the attendant care provider took place since that date, a period of over 2 years.</p> <p>During an interview on 1/7/19 at 11:05 a.m. the Administrator stated that the patient was on services for a long time and that no changes occurred.</p> <p>Based on observation, record review, and interview the agency failed to ensure ongoing patient education to meet the patient's individual needs in 1 of 1 patients with skin integrity and diet</p>	G 0610	<p>The administrator will in-service all staff on the coordination of patient care policy.</p> <p>Upon admission and re-certification pertinent teaching information associated with the patient diagnosis will be developed and on the 485. Education will be</p>	01/18/2019

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	<p>issues out of a total of 7 records reviewed. (Patient 7)</p> <p>Findings include:</p> <p>1. A policy titled Patient Education was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated but was not limited to "Based on patient's condition, physician ordered care and assessed needs, patient/family will receive education, as appropriate, about: plan of care ... nutritional intervention ... The patient education provided will be: ... Documented."</p> <p>2. A policy titled Plan for Patient/Family Education was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated but was not limited to "The Agency staff understands that the assessment of patient/family's education needs are ongoing and will be regularly reassessed as needs change. All patient/family education, the perceived comprehension, ability to demonstrate a taught skill and verbal recall will be documented in the patient's medical record."</p> <p>3. An agency procedure manual was provided by the Administrator on 1/4/19 at 1:30 p.m. The manual contained a procedure for Medical Nutrition Therapy: Pressure Ulcers which states, "to provide instruction on appropriate nutritional measures to prevent PUs to offer nutritional interventions for treatment of existing PUs ..." The procedure for nutrition therapy went on to state, "Document the following on the visit report: The procedure and patient toleration, vital signs, Calorie, protein, and fluid requirements of the patient, Medical treatment used for PUs, Nutrition interventions/treatment used for PUs, Analysis of the patient's food intake and the modifications suggested, Patient/caregiver instruction and</p>		<p>provided by all skilled professionals at each visit and document what was taught, comprehension or return demonstration from patient or caregiver</p> <p>The director of clinical services will review all admissions and re-certifications to ensure pertinent teaching information is provided to patient and caregiver.</p> <p>The administrator will in-service all nursing staff on patient education policy,</p>		

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	<p>response to teaching, including understanding of the diet and adherence to nutritional recommendations, Answers to feedback questions, Physician notification, if applicable, Standard Precautions, Other pertinent findings, Update the plan of care."</p> <p>4. During an observation on 1/3/19 at 3 p.m. the Administrator, who was an RN, conducted a home visit with Patient 7. The RN had the patient demonstrate how he/she was able to use the right handle of his electric wheelchair and tilt his upper body from sitting to lying position in order to help reduce pressure to his/her buttock region. The patient uses a mechanical lift and was totally dependent on all transfers.</p> <p>5. The clinical record for Patient 7, certification period 9/21/18 to 11/19/18, was reviewed on 1/3/19 and included a Plan of Care. The Plan of Care failed to evidence the need to provide education regarding healthy food choices and portion size.</p> <p>6. The patient's diagnoses were pressure ulcer left buttock, obesity, chronic COPD, and cerebral palsy. Patient 7's clinical record contained the following regarding diet and wound assessments:</p> <p>Nursing Visit Records dated for 9/21, 9/25, 9/26, 9/27, 9/28, 10/1, 10/2, 10/4, 10/5, 10/8, 10/9, 10/10, 10/11, 10/12, 10/13, 10/15, 10/16, 10/19, 10/22 and 10/23 of 2018 indicated the patient was "obese and overeats every meal" and the patient snacks and makes poor food choices. The Nurse Visit Records failed to evidence ongoing education or instructions regarding healthy food choices and portion size were provided to the patient.</p> <p>Nursing Visit Record dated for 10/11/18 evidenced wound measurements of 1.0 cm X 1.0 cm and that</p>			

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	<p>left buttock was dark pink with surrounding edges. The clinical record for Patient 7 evidenced one measurement for an open wound during the entire 9/21/18 to 11/19/18 certification period. The agency failed to measure ongoing redness and assessments for the certification period of 9/21/18 to 11/19/18. The agency failed to provide ongoing education regarding preventative measures to prevent skin breakdown and pressure ulcers.</p> <p>An unsigned 60 Day Summary (cont.) note dated 11/16/18 states, " ... Open wounds to B (bilateral) buttocks are presently healed, but his skin remains very fragile. Fragile skin care continues as ordered. He is instructed to turn side to side in bed & tilt frequently when up in his w/c. The open wounds come and go, this can change overnight or from one dressing change to the next. The skin on bilateral buttocks is very thin & fragile ..." The record also failed to address weight and nutrition needs.</p> <p>The Oasis Re-Assessment Follow-Up record dated 11/16/18 Measurable Goals and Outcomes section failed to address the patient's skin and mucous membranes, management of weight and diet. Patient 7's weight was 300+.</p> <p>The Plan of Care for the certification period 11/20/18 to 01/18/19 for Patient 7 included diagnoses of pressure ulcer to right and left buttock dated 11/16/18. The patient acquired a second pressure ulcer since last certification period.</p> <p>During an interview on 1/4/19 at 10:10 a.m. the Administrator was asked what the root cause of the patient's skin issues were. The Administrator responded that the patient's skin issues to his/her buttocks was from obesity due to overeating,</p>			

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G 0682 Bldg. 00	<p>immobility, and pressure. The Administrator stated at times the skin to the patient's buttocks opens when the dressing was taken off by staff, and that was also the reason why the dressing gets changed not more than two days a week. The Administrator stated the patient receives verbal reminders to stay off his bottom. The Administrator stated the patient had been with the agency for several years and early on the patient was educated on nutrition and diet but not recently.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Home Health Aide washed hands and wore gloves appropriately during 1 of 1 home health aide visit observed. (Patient 6)</p> <p>Findings include:</p> <p>A policy, revised 2016, and titled, "Hand Hygiene Policy and Compliance Program," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Indications for staff performing hand hygiene are: Before and after direct patient care; Before and after each procedure; After any contact with contaminated materials; Before re-entering nursing bag or patient's clean supplies."</p> <p>During an observation on 1/4/19 at 10:32 a.m., Employee F was observed to assist Patient 6 with a shower in his home. Employee F hand sanitized, applied gloves, and proceeded with the shower. After the shower was completed, patient was dried, then transferred to sit on the commode.</p>	G 0682	<p>All Home Health Aides will be in-serviced on infection prevention and the hand hygiene policy. SN will observe Home Health Aides during supervisory visit to ensure infection prevention steps are taken. Administrator will in-service all field staff on hand hygiene policy,</p>	01/25/2019

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G 0700 Bldg. 00	<p>Employee F was observed to remove her gloves. No hand hygiene was observed. Employee F put deodorant on Patient 6, assisted with dressing, assisted to stand, and dried patient's buttocks with a towel. No gloves were observed to be on Employee F's hands. During this time, Employee F indicated she should have worn gloves to dry the patient's buttocks. Employee F then combed patient 6's hair, placed the comb in her scrub pocket to towel dry the patient's hair, then pulled the comb out to comb the hair again. No hand hygiene was observed. Employee F took patient in the wheelchair to the kitchen then gathered supplies to shave the patient. Employee F applied gloves. No hand hygiene was observed. Employee F shaved Patient 6's face, then removed gloves and performed hand hygiene.</p> <p>Based on record review, the Registered Nurse failed to ensure visit notes contained complete wound assessments in the patient's condition (See G706); failed to ensure the plan of care included anatomical position of wounds and was specific in the interventions to be provided in the management of the wounds (See G708); to ensure care and services were provided per the plan of care (See G710); failed to ensure the physician was notified of changes in a patients skin integrity (See G718); and failed to ensure they followed facility policy to ensure supervisory visits on the LPNs (Licensed Practical Nurse) were conducted monthly (See G726).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to provide care</p>	G 0700	<p>Assess and document all wounds at every visit including anatomical location is on the nursing notes and the 485. Specific interventions will be laid out on the 485. All patient 485 have been audited to ensure proper care is being provided. The SN will notify the physician of any skin integrity changes. there will be an onsite visit monthly to supervise the LPN's.</p> <p>Staff will be in-serviced to notify the office of any changes in scheduling so the the director of clinical services/administrator can telephone the physician. the SN's will be in-serviced on proper wound assessment, measurement,</p>	02/01/2019

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G 0706 Bldg. 00	<p>and services in a safe and effective manner. The agency was found to be out of compliance with this condition, 42 CFR 484.75 Skilled Professional Services.</p> <p>Based on record review, the Registered Nurse failed to ensure visit notes contained complete wound assessments in the patient's condition in 1 of 1 patients with skin integrity issues out of a total of 7 records reviewed. (Patient 7)</p> <p>Findings include:</p> <p>Review of an article dated January 7, 2016 from RN.com, indicated " ... Regular skin assessment, risk evaluation, skin care interventions, mobility assessment, and nutrition evaluation are all equal components of prevention and treatment of pressure ulcers ... Assess any wounds or reddened areas of skin. This assessment includes: ... location, size, depth of the wound, type of tissue present ... how to document for pressure ulcers: 1. Pressure ulcer stage 2. Anatomical location 3. Wound measurements 4. Appearance of wound bed 5. Assessment of drainage 6. Condition of periwound skin 7. Wound care performed 8. Patients tolerance to wound care 9. Wound progress towards goal "</p> <p>The clinical record for Patient 7, certification</p>	G 0706	<p>interventions, physician notifications and documentation. LPN on site supervision monthly will be done by the RN. The administrator/director of clinical services will review notes weekly to ensure all notifications have been made.</p> <p>Assess and document all wounds at every visit including anatomical location is on the notes and the 485. The SN's will be in-serviced on proper wound assessment, measurements, interventions, physician notification and documentation. The administrator/ director of clinical services will review notes weekly to ensure all notifications have been made.</p>	02/01/2019

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G 0708 Bldg. 00	<p>period 9/21/18 to 11/19/18, start of care date 3/25/18, was reviewed on 1/3/19, with orders for wound treatments " ... Apply Endofoam wet with normal saline to open wounds "</p> <p>Review of the agency's nursing visit notes dated 9/21, 10/29, and 11/7/18, indicated the patients dressings were changed but failed to include an assessment.</p> <p>Review of the agency's nursing visit notes dated 9/20, 9/21, 9/25, 9/26, 9/27, 9/28, 10/1, 10/2, 10/4, 10/5, 10/9, 10/12, 10/13, 10/15, 10/16, 10/19, 10/22, 10/23, 10/24, 10/26, 10/29, 10/30, 10/31, 11/1, 11/2, 11/5, 11/6, 11/7, 11/8, 11/9, 11/12, 11/13, 11/14, 11/15, 11/16, 11/19 of 2018, failed to evidence measurements of the stage I pressure wounds. The record only evidenced wound measurement to the right buttock on 10/8/18 and the left buttock on 10/10 and 10/11/18.</p> <p>Review of a nursing visit note dated 10/8/18, indicated the patient had an open area to the right buttock that measured 1 x 1 centimeter. Review of the nursing visit note dated 10/9/18, failed to evidence if the wound was still open or if it had healed.</p> <p>During an interview on 1/4/19 at 10:10 a.m. the Administrator stated the agency did not routinely measure redness and did not routinely call the physician with changes to color such as from red to purple.</p> <p>Based on record review, the Registered Nurse failed to ensure the plan of care included</p>	G 0708	Assess and document all wounds at every visit including anatomical location is on the notes and the	02/01/2019

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G 0710 Bldg. 00	<p>anatomical position of wounds and was specific in the interventions to be provided in the management of the wounds in 1 of 1 patients with skin integrity issues out of a total of 7 records reviewed. (Patient 7)</p> <p>Findings include:</p> <p>Review of an article dated January 7, 2016 from RN.com, indicated " ... Regular skin assessment, risk evaluation, skin care interventions, mobility assessment, and nutrition evaluation are all equal components of prevention and treatment of pressure ulcers ... how to prevent pressure ulcers 1. Skin assessment 2. Pressure reduction/ repositioning 3. Support surfaces 4. Managing Incontinence 5. Nutrition support 6. Patient/ caregiver education 7. Emerging Therapies for Prevention of Pressure Ulcers ... how to document for pressure ulcers ... 2. Anatomical location "</p> <p>The clinical record for Patient 7, start of care 3/25/18, was reviewed on 1/3/19. The record contained a plan of care for the certification period of 9/21/18 to 11/19/18, with wound orders for the skilled nurse to " ... Apply Endofoam wet with normal saline to open wounds ... interventions to prevent pressure ulcers. " The order failed to identify an anatomical position of all the wounds and failed to include the specific interventions in the prevention of pressures such as educate and reinforce positioning, ensure pressure relieving devices are up to date and in working order, and diet education.</p> <p>Based on record review and interview the agency</p>	G 0710	<p>485. Specific interventions will be laid out in the 485. The SN's will be in-serviced on proper wound assessment, measurements, interventions, physician notification and documentation. The administrator/ director of clinical services will review notes weekly to ensure all notifications have been made.</p> <p>All 485 have been audited to ensure proper care is being</p>	02/01/2019	

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	<p>failed to ensure care and services were provided per the plan of care for 1 of 7 records reviewed. (Patient 1)</p> <p>Findings include:</p> <p>1. A policy, revised 2015, and titled, "Plan of Care - CMS #485 and Physician's Orders," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Newly identified patient's medical, nursing, and rehabilitative needs are addressed in updates to the Plan of Care. Care and services will be provided according to physicians orders. Orders are current and updated. If the agency provides fewer visits than the physician orders, it has altered the plan of care and the physician must be notified. The Agency must maintain documentation in the clinical record indicating that the physician was notified and is aware of the missed visit."</p> <p>2. During a record review on 1/2/19 at 1:55 p.m., Patient 1's most recent 485 (plan of care) order for the certification period of 11/10/2018 - 01/08/2019 indicated an order for Skilled Nurse 8 (eight) hours daily 3 - 5 (three to five) times per week times 9 (nine) weeks.</p> <p>Patient 1's Nursing Visit Records were reviewed and failed to evidence that 8 hours of SN were provided as indicated by the following:</p> <p>A skilled nurse visit by Employee G on 11/14/18 from 7:30 a.m. to 2:30 p.m. which indicated a visit of 7 (seven) hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p>		<p>provided.</p> <p>Staff has been in-serviced to notify the office of any changes in scheduling so the the physicians office can be notified by the director of clinical services/administrator/assistant administrator.</p> <p>The administrator/director of clinical services will review notes weekly to ensure all notifications have been made.</p>	

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	<p>A skilled nurse visit by Employee G on 11/15/18 from 9:30 a.m. to 4:30 p.m. which indicated a visit of 7 hours. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A communication note written by Employee D on 12/21/18 indicated Patient 1's family member called to report they would be on vacation until 12/28/18 and would not need visits. The clinical record lacked documentation of physician notification of missed visits and a written order.</p> <p>A skilled nurse visit by Employee G on 11/28/18 from 7:30 a.m. to 2:30 p.m. which indicated a visit of 7 hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A skilled nurse visit by Employee G on 12/5/18 from 7:30 a.m. to 2:30 p.m. which indicated a visit of 7 hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A skilled nurse visit by Employee G on 12/12/18 from 7:30 to 2:30 p.m. which indicated a visit of 7 hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>3. During an interview on 1/2/19 at 3:22 p.m., the Administrator indicated a communication note and physician notification should occur with missed visits.</p> <p>4. During an interview on 1/3/19 at 1:59 p.m.,</p>			

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G 0718 Bldg. 00	<p>Employee D indicated according to Patient 1's current orders, the nurse should be in the home for 8 hours.</p> <p>Based on record review and interview, the skilled nurse failed to ensure the physician was notified of changes in a patients skin integrity in 1 of 1 patients with skin impairment issues out of a total of 7 records reviewed. (Patient 7)</p> <p>Findings include:</p> <p>A policy titled Nursing Services was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated but was not limited to "Informing the physician and other staff of changes in the patient's needs"</p> <p>The clinical record for Patient 7, start of care 3/25/18, was reviewed on 1/3/19, and contained a plan of care for the certification period of 9/21/18 to 11/19/18, with wound orders for the skilled nursing to provide treatment to the patient wounds.</p> <p>Review of a skilled nursing visit notes from 9/21/18 to 10/7/18 indicated the wound was intact. On 10/8/18, the skilled nursing visit note indicated the patient had an open area on the right buttock that measured 1 x 1 centimeters. On 10/10 and 10/11/18, the skilled nursing visit notes indicated the patient had an open area to the left buttock that measured 1 x 1 centimeters. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p>	G 0718	<p>The SN's will notify the physician of any patient skin integrity changes.</p> <p>The SN's will be in-serviced on proper wound assessment, measurements, interventions, physician notification and documentation.</p> <p>The administrator/ director of clinical services will review notes weekly to ensure all notifications have been made.</p>	02/01/2019

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G 0726 Bldg. 00	<p>Review of a skilled nursing visit note dated 9/27/18, indicated the patient's pressure ulcers on the buttocks was red and surround tissue was dark pink. On 9/28/18, the skilled nursing visit note indicated the wounds were dark red and surrounding tissue was dark pink. On 10/5 and 10/8/18 the skilled nursing visit note indicated the wounds were red and purple. On 10/9/18, the skilled nursing visit note indicated the wounds were very red and dark purple. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>Review of a skilled nursing visit note dated 10/12/18, indicated the patient's pressure ulcers on the buttocks were blanchable. On 10/19/18, the skilled nursing visit note indicated the patient's pressure ulcers was non-blanchable. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>During an interview on 1/4/19 at 10:10 a.m., the Administrator stated the agency did not routinely call the physician with changes to color such as from red to purple.</p> <p>Based on record review and interview, the RN (Registered Nurse) failed to ensure they followed facility policy to ensure supervisory visits on the LPNs (Licensed Practical Nurse) were conducted monthly for 1 of 5 current patients reviewed. (Patient 1)</p> <p>Findings include:</p>	G 0726	There will be an onsite visit monthly to supervise the LPN's. LPN's on site supervision will be done by the RN. The scheduler will keep a calendar of all supervisory visits that need to be made and will put them on the RN's weekly schedule. The Administrator is responsible	02/01/2019

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	<p>A policy, revised 2014, and titled, "Nursing Services," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Supervising LVN/LPNs and paraprofessionals providing services. The LPN/LVN will be supervised by the RN at least monthly."</p> <p>During a record review on 1/2/19 at 1:55 p.m., Patient 1's record indicated a supervisory visit by Employee D (an RN) on 11/2/18, 11/30/18, and 12/28/18. The supervisory visits for the LPN indicated the following: Follows and implements the care plan; Maintains and implements Standard Precaution per agency policy; Prompt, stays required length of time and is reliable; Appears competent in the delivery of service; Performs tasks as requested by the patient within job description; Relates well with the patient/family; Adheres to the dress code; Reports complications and problems to case manager/supervisor; Caring and sympathetic to the patient's needs. The supervisory visits for the LPN indicated: The agency admit folder is readily available; The patient has a continued need for services; The care plan has been updated as required."</p> <p>During an interview on 1/3/19 at 11:25 a.m., Employee G (an LPN - Licensed Practical Nurse) indicated she would see Patient 1 every Monday through Friday for eight hours per day. Employee G indicated no RN visits had conducted in Patient 1's home.</p> <p>During an interview on 1/3/19 at 1:59 p.m., Employee D indicated supervisory visits were done by the RN via phone with Patient 1's mother since they were not there during the LPN visits.</p>		for in-servicing the scheduler and the RN's on this. The director of clinical services will review charts weekly to ensure all supervisory visits are done in the proper time frame.		

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G 0798 Bldg. 00	<p>During an interview on 1/3/19 at 2:34 p.m., Employee D indicated an RN only goes to see Patient 1 if needed.</p> <p>Based on observation, record review, and interview the agency failed to provide written care instructions on the aide plan of care regarding cleaning of equipment in 1 of 2 records with home health aide visits and failed to adequately specify the frequency for completing each task assigned to the home health aide in 2 of 2 records with home health aide visits. (Patient 6, 7)</p> <p>Findings include:</p> <p>1. A policy, revised 2014, and titled, "Care Planning Process," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "The patient care plan for the Home Health Aide will be: Home Health Aide assignment sheet: developed by a Registered Nurse prior to Home Health Aide rendering care. The assignment sheet/plan of care will be communicated to the Home Health Aide by the appropriate discipline. The assignment sheet/plan of care will include: Type service/procedure to be provided; Frequency of visits; Diagnosis prognosis, if relevant to care; Functional limitation; Patient's mental status; Activities permitted; Specific procedure to be performed including amount, frequency and duration."</p> <p>2. The clinical record of patient #6, certification period of 11/29/18 to 1/27/19, was reviewed on 1/3/19 at 2:49 p.m.</p>	G 0798	<p>All home health aides will be given updated aide assignment sheets that have specific frequency and detailed instructions for cleaning and maintaining equipment, Each time there is a change made to the aide assignment sheet a copy will be given to the home health aide with the updates.</p> <p>The director of clinical services will review the charts weekly to ensure the aide assignment sheets are appropriate.</p> <p>The administrator will in-service field staff on the more specific aide assignment sheets.</p>	02/01/2019

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	<p>The clinical record contained a home health aide care plan dated 11/29/18. The Home Health Aide Care Plan stated vital signs, bathing, hand/foot care, elimination, skin care, activity, meals, and housekeeping were to be done every) visit as needed. The Home Health Aide Care Plan failed to adequately specify the frequency for completing each task.</p> <p>During an interview on 1/4/19 at 10:18 a.m., Employee F indicated she did not use the Home Health Aide Care Plan because that was the nurses paper that they fill out. Employee F indicated she did whatever the patient needed done at each visit. Employee F indicated when going out to see a new patient, one of the nurses at the office would call to inform them about the patient and their needs.</p> <p>During an interview on 1/4/19 at 2:45 p.m., the Administrator indicated the home health aides were supposed to follow the home health aide care plan. The home health aide care plan was usually marked with all prn since it's the patient's choice. 3. The clinical record for Patient #7, certification period 9/21/18 to 11/19/18 was reviewed on 1/4/19 at 11:39 a.m.</p> <p>Review of the Home Health Aide Progress Note dated 11/8/18 stated, "Equipment Cleaned: vent cleaned & blue condenser". Home Health Aide Progress Notes for 11/6, 11/7 and 11/8 of 2018 stated the urinal drainage bag was cleaned with vinegar.</p> <p>Review of a Home Health Aide Care Plan, stated that vital signs, bathing, hand/ foot care, elimination, skin care, activity, meals and housekeeping were done every visit prn as</p>			

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G 0800 Bldg. 00	<p>needed. The Home Health Aide Care Plan failed to evidence instructions regarding the cleaning of patient equipment and failed to adequately specify the frequency for completing each task.</p> <p>During an interview on 1/4/19 at 3 p.m. the Administrator acknowledged the aide plan of care lacked instructions on cleaning patient equipment and stated the agency allowed the patient to choose what tasks would be performed at each visit.</p> <p>Based on record review and interview, the home health aide failed to ensure care and services were provided as ordered by the physician in 1 of 3 patients that receive home health aide visits. (Patient 2)</p> <p>Findings include:</p> <p>A policy titled Care Planning Process was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy included but was not limited to "Care and services provided will be provided according to physician orders. Orders are current and updated"</p> <p>The clinical record for Patient 2, certification period 12/11/18 to 2/8/19, start of care 11/3/14, was reviewed on 1/2/19. The Plan of Care included orders for home health aide services for 10 hour days times 7 days a week. The record failed to evidence home health aide visits were conducted for the full 10 hours on the following dates: 11/22, 11/26, 12/4, 12/11, 12/18, 12/24, and 12/25 of 2018.</p>	G 0800	<p>We have ensured the proper amount of time is now scheduled and matches what is ordered by the physician.</p> <p>Closer attention will be paid to client schedule changes and the physician will be notified of any changes. The staff was in-serviced on when to notify office of schedule changes so the Dr. can be informed.</p> <p>The administrator is responsible for in-servicing staff and delegating who and when to make phone calls. The Director of clinical services will review charts weekly to ensure patients receive proper amounts of time and that physicians have been notified if necessary.</p>	01/21/2019

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G 0964 Bldg. 00	<p>During an interview on 1/4/19 at 3 p.m. the Administrator acknowledged the home health aide visits were not conducted according to the physician's order.</p> <p>Based on observation, record review, and interview, the facility failed to follow their policy and ensure patient referral forms were completed in order to determine when initial assessments needed to be completed in 7 of 7 records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A policy, revised 2014, titled, "Patient Admission Criteria," was provided by Assistant Administrator on 1/2/19 at 1:54 p.m. The policy indicated, but was not limited to, "When a telephone referral is received by the Agency, a referral form is completed by a RN. Referrals may also be received by fax, in person or in the mail. The referral form includes at least the following information: Patient identification, e.g. name, address, telephone number, date of birth, sex, Medicare or social security number, insurance information, emergency contact and telephone number; Physician's name, address and telephone number; Referral source; Primary and other diagnosis (es); Medications and treatments required; Date of hospital discharge, if applicable; Care or treatments to be provided, including frequency and duration; Any other information reported by the referral source. A log of all referrals received is maintained by the Agency." 2. During a record review on 1/2/19 at 1:55 p.m., 	G 0964	<p>The agency developed a new referral sheet to be utilized when a new referral is received. All referrals will be documented and included in patient assessment packets to be placed in the chart. Administrator in-serviced nursing staff on patient admission criteria policy.</p>	01/11/2019

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	<p>Patient 1's record lacked referral documentation and therefore, the agency could not evidence if patient's were assessed within 48 hours.</p> <p>3. During a record review on 1/3/19 at 2:49 p.m., Patient 6's record lacked referral documentation and therefore, the agency could not evidence if patient's were assessed within 48 hours.</p> <p>4. During a record review on 1/4/19 at 11:29 a.m., Patient 4's record lacked referral documentation and therefore, the agency could not evidence if patient's were assessed within 48 hours.</p> <p>5. During a record review on 1/4/19 at 2:30 p.m., Patient 5's record lacked referral documentation and therefore, the agency could not evidence if patient's were assessed within 48 hours.</p> <p>6. During a record review on 1/2/19 at 1:30 p.m., Patient 2's record lacked referral documentation and therefore, the agency could not evidence if patient's were assessed within 48 hours.</p> <p>7. During a record review on 1/3/19 at 2:30 p.m., Patient 7's record lacked referral documentation and therefore, the agency could not evidence if patient's were assessed within 48 hours.</p> <p>8. During a record review on 1/4/19 at 10 a.m., Patient 3's record lacked referral documentation and therefore, the agency could not evidence if patient's were assessed within 48 hours.</p> <p>9. During an interview on 1/2/19 at 1:47 p.m., the Assistant Administrator indicated when a referral was received, she would write it in her notebook, but did not document in the patient's record but was not provided. The Assistant Administrator indicated no log of referrals were documented.</p>			

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G 1024 Bldg. 00	<p>Based on record review and interview, the facility failed to ensure a recertification visit was appropriately signed by the staff member with their name and title for 1 of 7 records reviewed. (Patient 1)</p> <p>Findings include:</p> <p>A policy, revised 2014, and titled, "Nursing Services," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Professional nursing services will be provided by a registered nurse and include: Initial and ongoing comprehensive assessments of the patient's needs, including Outcome and Assessment Information Set (OASIS) assessments at appropriate points."</p> <p>During a record review on 1/2/19 at 1:55 p.m., Patient 1's record indicated a recertification visit on 11/8/18 with time in and time out listed as "-NA-" (not applicable). The recertification visit note was not signed by any staff member.</p> <p>During an interview on 1/3/19 at 2:32 p.m., the Assistant Administrator indicated all recertification visit notes should be signed by the nurse.</p>	G 1024	<p>All documents will be signed, dated and credentialed by appropriate staff.</p> <p>The Assistant administrator will review all assessments to ensure proper signatures are in place.</p> <p>The administrator will in-service nursing staff and office staff of the nursing services policy.</p> <p>The director of clinical services will review documents weekly to ensure all document have proper authentication, dates and credentials</p>	01/25/2019
N 0000 Bldg. 00	<p>This was a State home health re-licensure survey.</p> <p>Survey Dates: January 2, 3, 4, and 7, 2019</p>	N 0000		

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N 0470 Bldg. 00	<p>Facility #: 009488</p> <p>Medicare Provider #: 157483</p> <p>Medicaid Vendor #: 200198250</p> <p>Census: 12</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Home Health Aide washed hands and wore gloves appropriately during 1 of 1 home health aide visit observed. (Patient 6)</p> <p>Findings include:</p> <p>A policy, revised 2016, and titled, "Hand Hygiene Policy and Compliance Program," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Indications for staff performing hand hygiene are: Before and after direct patient care; Before and after each procedure; After any contact with contaminated materials; Before re-entering nursing bag or patient's clean supplies."</p> <p>During an observation on 1/4/19 at 10:32 a.m., Employee F was observed to assist Patient 6 with a shower in his home. Employee F hand sanitized, applied gloves, and proceeded with the shower. After the shower was completed, patient was</p>	N 0470	All Home Health Aides will be in-serviced on infection prevention and the hand hygiene policy. SN will observe Home Health Aides during supervisory visit to ensure infection prevention steps are taken. Administrator will in-service all field staff on hand hygiene policy,	01/25/2019

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N 0484 Bldg. 00	<p>dried, then transferred to sit on the commode. Employee F was observed to remove her gloves. No hand hygiene was observed. Employee F put deodorant on Patient 6, assisted with dressing, assisted to stand, and dried patient's buttocks with a towel. No gloves were observed to be on Employee F's hands. During this time, Employee F indicated she should have worn gloves to dry the patient's buttocks. Employee F then combed patient 6's hair, placed the comb in her scrub pocket to towel dry the patient's hair, then pulled the comb out to comb the hair again. No hand hygiene was observed. Employee F took patient in the wheelchair to the kitchen then gathered supplies to shave the patient. Employee F applied gloves. No hand hygiene was observed. Employee F shaved Patient 6's face, then removed gloves and performed hand hygiene.</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on record review and interview, the facility failed to ensure an coordination of care between staff members were documented in the clinical record in 2 of 2 clinical records reviewed with more than one certification period (Patient 1 and 4)</p> <p>Findings include:</p> <p>1. A policy, revised 2014, and titled, "Coordination of Patient Care," was provided by</p>	N 0484	<p>Case Conferences will be held weekly and any time there is a change. These will be documented in patient charts.</p> <p>The director of clinical services will review charts weekly to ensure case conference documentation is in the patient charts.</p> <p>Administrator will in-service staff on coordination of patient care policy.</p>	02/01/2019	

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N 0486 Bldg. 00	<p>the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Case conferences are held on an ongoing basis to discuss any new admissions, patients to be recertified within the next 30 days and any problems. Documentation of case conferences will be maintained in the patient's medical record."</p> <p>2. During a record review on 1/2/19 at 1:55 p.m., Patient 1's clinical record indicated a start of care date of 7/18/17. Patient 1's clinical record lacked documentation of an interdisciplinary case conference to discuss recertifications.</p> <p>3. During a record review on 1/4/19 at 11:29 a.m., Patient 4's clinical record indicated a start of care date of 10/17/18. Patient 4's clinical record lacked documentation of an interdisciplinary case conference to discuss recertification or discharge.</p> <p>During an interview on 1/2/18 at 3:05 p.m., Employee D indicated any notes on conferencing would be at the bottom of the nursing visit records and there was no formal case conference. Employee D stated two nurses in the office would discuss recertification and/or discharge. Employee D indicated the discussions were not written down anywhere and there were no case conference notes.</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on record review and interview the agency failed to follow agency policy on coordination of patient care with other providers for 1 of 2 patients that receive care from other providers.</p>	N 0486	We will coordinate care with external organizations at least every 60 days when doing an oasis visit or when significant changes occur and relevant	02/01/2019

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N 0522	<p>(Patient 2)</p> <p>Findings include:</p> <p>A policy titled Coordination of Patient Care was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated but was not limited to "Care will be coordinated with other involved external organizations, e.g., home medical equipment providers, infusion therapy/pharmacy companies and community agencies. Staff will: Understand Agency and organization's responsibilities in providing care or services. Communicate with other individuals or organizations involved in the patient's care when significant changes occur in the patient's overall care. Share relevant information to facilitate appropriate continuity and care coordination."</p> <p>On 1/7/19 at 11 a.m. reviewed the clinical record for Patient 2, certification period 12/11/18 to 2/8/19, start of care date 11/3/14. The clinical record included orders for attendant care services 3.5 hours per day for 7 days a week to be provided by another agency. The clinical record included documentation that Coordination of Care took place on 3/2/16 with the attendant care provider, and indicated that 4.5 hours per day of attendant care services were to be provided. The record failed to evidence that any Coordination of Care with the attendant care provider took place since that date, a period of over 2 years.</p> <p>During an interview on 1/7/19 at 11:05 a.m. the Administrator stated that the patient was on services for a long time and that no changes occurred.</p> <p>410 IAC 17-13-1(a) Patient Care</p>		<p>information needs to be shared. The director of clinical services will review all oasis visits to ensure they include a case conference will all pertinent external organizations. The administrator will in-service all staff on the coordination of patient care policy.</p>		

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Bldg. 00	<p>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 record review and interview, the home health aide failed to ensure care and services were provided as ordered by the physician in 1 of 3 patients that receive home health aide visits. (Patient 2)</p> <p>Findings include:</p> <p>A policy titled Care Planning Process was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy included but was not limited to "Care and services provided will be provided according to physician orders. Orders are current and updated"</p> <p>The clinical record for Patient 2, certification period 12/11/18 to 2/8/19, start of care 11/3/14, was reviewed on 1/2/19. The Plan of Care included orders for home health aide services for 10 hour days times 7 days a week. The record failed to evidence home health aide visits were conducted for the full 10 hours on the following dates: 11/22, 11/26, 12/4, 12/11, 12/18, 12/24, and 12/25 of 2018.</p> <p>During an interview on 1/4/19 at 3 p.m. the Administrator acknowledged the home health aide visits were not conducted according to the physician's order.</p>	N 0522	<p>We have ensured the proper amount of time is now scheduled and matches what is ordered by the physician. Closer attention will be paid to client schedule changes and the physician will be notified of any changes. The staff was in-serviced on when to notify office of schedule changes so the Dr. can be informed. The administrator is responsible for in-servicing staff and delegating who and when to make phone calls. The Director of clinical services will review charts weekly to ensure patients receive proper amounts of time and that physicians have been notified if necessary.</p>	01/21/2019	
N 0527	410 IAC 17-13-1(a)(2) Patient Care				
Bldg. 00	Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care				

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	<p>to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on record review and interview, the agency failed to ensure the physician was notified of changes in a patients skin integrity in 1 of 1 patients with skin impairment issues out of a total of 7 records reviewed. (Patient 7)</p> <p>Findings include:</p> <p>A policy titled Nursing Services was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated but was not limited to "Informing the physician and other staff of changes in the patient's needs"</p> <p>The clinical record for Patient 7, start of care 3/25/18, was reviewed on 1/3/19, and contained a plan of care for the certification period of 9/21/18 to 11/19/18, with wound orders for the skilled nursing to provide treatment to the patient wounds.</p> <p>Review of a skilled nursing visit notes from 9/21/18 to 10/7/18 indicated the wound was intact. On 10/8/18, the skilled nursing visit note indicated the patient had an open area on the right buttock that measured 1 x 1 centimeters. On 10/10 and 10/11/18, the skilled nursing visit notes indicated the patient had an open area to the left buttock that measured 1 x 1 centimeters. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>Review of a skilled nursing visit note dated 9/27/18, indicated the patient's pressure ulcers on the buttocks was red and surround tissue was dark pink. On 9/28/18, the skilled nursing visit</p>	N 0527	<p>Physician was immediately notified of resolution of wounds on the patient.</p> <p>The RN will notify the physician and other appropriate medical personnel of any changes immediately after or during client visit.</p> <p>The director of clinical services will review nursing notes weekly to ensure all notifications have been made.</p>	01/17/2019

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N 0533 Bldg. 00	<p>note indicated the wounds were dark red and surrounding tissue was dark pink. On 10/5 and 10/8/18 the skilled nursing visit note indicated the wounds were red and purple. On 10/9/18, the skilled nursing visit note indicated the wounds were very red and dark purple. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>Review of a skilled nursing visit note dated 10/12/18, indicated the patient's pressure ulcers on the buttocks were blanchable. On 10/19/18, the skilled nursing visit note indicated the patient's pressure ulcers was non-blanchable. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>During an interview on 1/4/19 at 10:10 a.m., the Administrator stated the agency did not routinely call the physician with changes to color such as from red to purple.</p> <p>410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service.</p> <p>(b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits.</p>			

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	<p>(5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan.</p> <p>Based on observation, record review, and interview the agency failed to provide written care instructions on the aide plan of care regarding cleaning of equipment in 1 of 2 records with home health aide visits and failed to adequately specify the frequency for completing each task assigned to the home health aide in 2 of 2 records with home health aide visits. (Patient 6, 7)</p> <p>Findings include:</p> <p>1. A policy, revised 2014, and titled, "Care Planning Process," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "The patient care plan for the Home Health Aide will be: Home Health Aide assignment sheet: developed by a Registered Nurse prior to Home Health Aide rendering care. The assignment sheet/plan of care will be communicated to the Home Health Aide by the appropriate discipline. The assignment sheet/plan of care will include: Type service/procedure to be provided; Frequency of visits; Diagnosis prognosis, if relevant to care; Functional limitation; Patient's mental status; Activities permitted; Specific procedure to be performed including amount, frequency and duration."</p> <p>2. The clinical record of patient #6, certification period of 11/29/18 to 1/27/19, was reviewed on</p>	N 0533	<p>All home health aides will be given updated aide assignment sheets that have specific frequency and detailed instructions for cleaning and maintaining equipment, Each time there is a change made to the aide assignment sheet a copy will be given to the home health aide with the updates.</p> <p>The director of clinical services will review the charts weekly to ensure the aide assignment sheets are appropriate.</p> <p>The administrator will in-service field staff on the more specific aide assignment sheets.</p>	02/01/2019
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	<p>1/3/19 at 2:49 p.m.</p> <p>The clinical record contained a home health aide care plan dated 11/29/18. The Home Health Aide Care Plan stated vital signs, bathing, hand/foot care, elimination, skin care, activity, meals, and housekeeping were to be done every) visit as needed. The Home Health Aide Care Plan failed to adequately specify the frequency for completing each task.</p> <p>During an interview on 1/4/19 at 10:18 a.m., Employee F indicated she did not use the Home Health Aide Care Plan because that was the nurses paper that they fill out. Employee F indicated she did whatever the patient needed done at each visit. Employee F indicated when going out to see a new patient, one of the nurses at the office would call to inform them about the patient and their needs.</p> <p>During an interview on 1/4/19 at 2:45 p.m., the Administrator indicated the home health aides were supposed to follow the home health aide care plan. The home health aide care plan was usually marked with all prn since it's the patient's choice.3. The clinical record for Patient #7, certification period 9/21/18 to 11/19/18 was reviewed on 1/4/19 at 11:39 a.m.</p> <p>Review of the Home Health Aide Progress Note dated 11/8/18 stated, "Equipment Cleaned: vent cleaned & blue condenser". Home Health Aide Progress Notes for 11/6, 11/7 and 11/8 of 2018 stated the urinal drainage bag was cleaned with vinegar.</p> <p>Review of a Home Health Aide Care Plan, stated that vital signs, bathing, hand/ foot care, elimination, skin care, activity, meals and</p>			

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N 0537 Bldg. 00	<p>housekeeping were done every visit prn as needed. The Home Health Aide Care Plan failed to evidence instructions regarding the cleaning of patient equipment and failed to adequately specify the frequency for completing each task.</p> <p>During an interview on 1/4/19 at 3 p.m. the Administrator acknowledged the aide plan of care lacked instructions on cleaning patient equipment and stated the agency allowed the patient to choose what tasks would be performed at each visit.</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on record review and interview the agency failed to ensure care and services were provided per the plan of care for 1 of 7 records reviewed. (Patient 1)</p> <p>Findings include:</p> <p>1. A policy, revised 2015, and titled, "Plan of Care - CMS #485 and Physician's Orders," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Newly identified patient's medical, nursing, and rehabilitative needs are addressed in updates to the Plan of Care. Care and services will be provided according to physicians orders. Orders are current and updated. If the agency provides fewer visits than the physician orders, it has altered the plan of care and the physician must be notified. The Agency must maintain</p>	N 0537	<p>We have ensured the proper amount of time is now scheduled and matches what is ordered by the physician.</p> <p>Closer attention will be paid to client schedule changes and the physician will be notified of any changes. The staff was in-serviced on when to notify office of schedule changes so the Dr. can be informed.</p> <p>The administrator is responsible for in-servicing staff and delegating who and when to make phone calls.</p>	01/21/2019

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	<p>documentation in the clinical record indicating that the physician was notified and is aware of the missed visit."</p> <p>2. During a record review on 1/2/19 at 1:55 p.m., Patient 1's most recent 485 (plan of care) order for the certification period of 11/10/2018 - 01/08/2019 indicated an order for Skilled Nurse 8 (eight) hours daily 3 - 5 (three to five) times per week times 9 (nine) weeks.</p> <p>Patient 1's Nursing Visit Records were reviewed and failed to evidence that 8 hours of SN were provided as indicated by the following:</p> <p>A skilled nurse visit by Employee G on 11/14/18 from 7:30 a.m. to 2:30 p.m. which indicated a visit of 7 (seven) hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A skilled nurse visit by Employee G on 11/15/18 from 9:30 a.m. to 4:30 p.m. which indicated a visit of 7 hours. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A communication note written by Employee D on 12/21/18 indicated Patient 1's family member called to report they would be on vacation until 12/28/18 and would not need visits. The clinical record lacked documentation of physician notification of missed visits and a written order.</p> <p>A skilled nurse visit by Employee G on 11/28/18 from 7:30 a.m. to 2:30 p.m. which indicated a visit of 7 hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of</p>			

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N 0541 Bldg. 00	<p>change and a written order.</p> <p>A skilled nurse visit by Employee G on 12/5/18 from 7:30 a.m. to 2:30 p.m. which indicated a visit of 7 hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>A skilled nurse visit by Employee G on 12/12/18 from 7:30 to 2:30 p.m. which indicated a visit of 7 hours. Employee G indicated Patient 1 had an early release from school. The visit note lacked documentation of physician notification of change and a written order.</p> <p>3. During an interview on 1/2/19 at 3:22 p.m., the Administrator indicated a communication note and physician notification should occur with missed visits.</p> <p>4. During an interview on 1/3/19 at 1:59 p.m., Employee D indicated according to Patient 1's current orders, the nurse should be in the home for 8 hours.</p> <p>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.</p> <p>Based on record review, the Registered Nurse failed to ensure visit notes contained complete wound assessments in the patient's condition in 1 of 1 patients with skin integrity issues out of a</p>	N 0541	Assess and document all wounds at every visit including anatomical location is on the notes and the 485. The SN's will be in-serviced on	02/01/2019

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	<p>total of 7 records reviewed. (Patient 7)</p> <p>Findings include:</p> <p>Review of an article dated January 7, 2016 from RN.com, indicated " ... Regular skin assessment, risk evaluation, skin care interventions, mobility assessment, and nutrition evaluation are all equal components of prevention and treatment of pressure ulcers ... Assess any wounds or reddened areas of skin. This assessment includes: ... location, size, depth of the wound, type of tissue present ... how to document for pressure ulcers: 1. Pressure ulcer stage 2. Anatomical location 3. Wound measurements 4. Appearance of wound bed 5. Assessment of drainage 6. Condition of periwound skin 7. Wound care performed 8. Patients tolerance to wound care 9. Wound progress towards goal "</p> <p>The clinical record for Patient 7, certification period 9/21/18 to 11/19/18, start of care date 3/25/18, was reviewed on 1/3/19, with orders for wound treatments " ... Apply Endofoam wet with normal saline to open wounds "</p> <p>Review of the agency's nursing visit notes dated 9/21, 10/29, and 11/7/18, indicated the patients dressings were changed but failed to include an assessment.</p> <p>Review of the agency's nursing visit notes dated 9/20, 9/21, 9/25, 9/26, 9/27, 9/28, 10/1, 10/2, 10/4, 10/5, 10/9, 10/12, 10/13, 10/15, 10/16, 10/19, 10/22, 10/23, 10/24, 10/26, 10/29, 10/30, 10/31, 11/1, 11/2, 11/5, 11/6, 11/7, 11/8, 11/9, 11/12, 11/13, 11/14, 11/15, 11/16, 11/19 of 2018, failed to evidence measurements of the stage I pressure wounds. The record only evidenced wound measurement to the right buttock on 10/8/18 and the left buttock</p>		<p>proper wound assessment, measurements, interventions, physician notification and documentation.</p> <p>The administrator/ director of clinical services will review notes weekly to ensure all notifications have been made.</p>	

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N 0542 Bldg. 00	<p>on 10/10 and 10/11/18.</p> <p>Review of a nursing visit note dated 10/8/18, indicated the patient had an open area to the right buttock that measured 1 x 1 centimeter. Review of the nursing visit note dated 10/9/18, failed to evidence if the wound was still open or if it had healed.</p> <p>During an interview on 1/4/19 at 10:10 a.m. the Administrator stated the agency did not routinely measure redness and did not routinely call the physician with changes to color such as from red to purple.</p> <p>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.</p> <p>Based on record review, the Registered Nurse failed to ensure the plan of care included anatomical position of wounds and was specific in the interventions to be provided in the management of the wounds in 1 of 1 patients with skin integrity issues out of a total of 7 records reviewed. (Patient 7)</p> <p>Findings include:</p> <p>Review of an article dated January 7, 2016 from RN.com, indicated " ... Regular skin assessment, risk evaluation, skin care interventions, mobility assessment, and nutrition evaluation are all equal components of prevention and treatment of</p>	N 0542	<p>Assess and document all wounds at every visit including anatomical location is on the notes and the 485. Specific interventions will be laid out in the 485.</p> <p>The SN's will be in-serviced on proper wound assessment, measurements, interventions, physician notification and documentation.</p> <p>The administrator/ director of clinical services will review notes weekly to ensure all notifications have been made.</p>	02/01/2019

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N 0545 Bldg. 00	<p>pressure ulcers ... how to prevent pressure ulcers 1. Skin assessment 2. Pressure reduction/ repositioning 3. Support surfaces 4. Managing Incontinence 5. Nutrition support 6. Patient/ caregiver education 7. Emerging Therapies for Prevention of Pressure Ulcers ... how to document for pressure ulcers ... 2. Anatomical location "</p> <p>The clinical record for Patient 7, start of care 3/25/18, was reviewed on 1/3/19. The record contained a plan of care for the certification period of 9/21/18 to 11/19/18, with wound orders for the skilled nurse to " ... Apply Endofoam wet with normal saline to open wounds ... interventions to prevent pressure ulcers. " The order failed to identify an anatomical position of all the wounds and failed to include the specific interventions in the prevention of pressures such as educate and reinforce positioning, ensure pressure relieving devices are up to date and in working order, and diet education.</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on record review and interview the agency failed to follow agency policy on coordination of patient care with other providers for 1 of 2 patients that receive care from other providers. (Patient 2)</p> <p>Findings include: A policy titled Coordination of Patient Care was</p>	N 0545	<p>We will coordinate care with external organizations at least every 60 days when doing an assessment visit or when significant changes occur and relevant information needs to be shared. The director of clinical services will review all assessment visits to ensure they include a case</p>	02/01/2019

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N 0546 Bldg. 00	<p>provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated but was not limited to "Care will be coordinated with other involved external organizations, e.g., home medical equipment providers, infusion therapy/pharmacy companies and community agencies. Staff will: Understand Agency and organization's responsibilities in providing care or services. Communicate with other individuals or organizations involved in the patient's care when significant changes occur in the patient's overall care. Share relevant information to facilitate appropriate continuity and care coordination."</p> <p>On 1/7/19 at 11 a.m. reviewed the clinical record for Patient 2, certification period 12/11/18 to 2/8/19, start of care date 11/3/14. The clinical record included orders for attendant care services 3.5 hours per day for 7 days a week to be provided by another agency. The clinical record included documentation that Coordination of Care took place on 3/2/16 with the attendant care provider, and indicated that 4.5 hours per day of attendant care services were to be provided. The record failed to evidence that any Coordination of Care with the attendant care provider took place since that date, a period of over 2 years.</p> <p>During an interview on 1/7/19 at 11:05 a.m. the Administrator stated that the patient was on services for a long time and that no changes occurred.</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:</p>		<p>conference will all pertinent external organizations. The administrator will in-service all staff on the coordination of patient care policy. The director of clinical services will review charts weekly to ensure 60-day case conferences include all pertinent external organizations.</p>		

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	<p>(G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on record review and interview, the skilled nurse failed to ensure the physician was notified of changes in a patients skin integrity in 1 of 1 patients with skin impairment issues out of a total of 7 records reviewed. (Patient 7)</p> <p>Findings include:</p> <p>A policy titled Nursing Services was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated but was not limited to "Informing the physician and other staff of changes in the patient's needs"</p> <p>The clinical record for Patient 7, start of care 3/25/18, was reviewed on 1/3/19, and contained a plan of care for the certification period of 9/21/18 to 11/19/18, with wound orders for the skilled nursing to provide treatment to the patient wounds.</p> <p>Review of a skilled nursing visit notes from 9/21/18 to 10/7/18 indicated the wound was intact. On 10/8/18, the skilled nursing visit note indicated the patient had an open area on the right buttock that measured 1 x 1 centimeters. On 10/10 and 10/11/18, the skilled nursing visit notes indicated the patient had an open area to the left buttock that measured 1 x 1 centimeters. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p>	N 0546	<p>Physician was immediately notified of resolution of wounds on the patient.</p> <p>The RN will notify the physician and other appropriate medical personnel of any changes immediately after or during client visit.</p> <p>The director of clinical services will review nursing notes weekly to ensure all notifications have been made.</p>	01/17/2019

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NAME OF PROVIDER OR SUPPLIER FRIENDS HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP COD 110 N 15TH ST VINCENNES, IN 47591
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0549 Bldg. 00	<p>Review of a skilled nursing visit note dated 9/27/18, indicated the patient's pressure ulcers on the buttocks was red and surround tissue was dark pink. On 9/28/18, the skilled nursing visit note indicated the wounds were dark red and surrounding tissue was dark pink. On 10/5 and 10/8/18 the skilled nursing visit note indicated the wounds were red and purple. On 10/9/18, the skilled nursing visit note indicated the wounds were very red and dark purple. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>Review of a skilled nursing visit note dated 10/12/18, indicated the patient's pressure ulcers on the buttocks were blanchable. On 10/19/18, the skilled nursing visit note indicated the patient's pressure ulcers was non-blanchable. The clinical record failed to evidence that the physician was notified of the changes in the patient's skin integrity.</p> <p>During an interview on 1/4/19 at 10:10 a.m., the Administrator stated the agency did not routinely call the physician with changes to color such as from red to purple.</p> <p>410 IAC 17-14-1(a)(1)(J) Scope of Services Rule 14 Sec. 1(a) (1)(J) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (J) Direct the activities of the licensed practical nurse.</p> <p>Based on record review and interview, the RN (Registered Nurse) failed to ensure they followed</p>	N 0549	There will be an onsite visit monthly to supervise the LPN's. LPN's on site supervision will be	02/01/2019

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	<p>facility policy to ensure supervisory visits on the LPNs (Licensed Practical Nurse) were conducted monthly for 1 of 5 current patients reviewed. (Patient 1)</p> <p>Findings include:</p> <p>A policy, revised 2014, and titled, "Nursing Services," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Supervising LVN/LPNs and paraprofessionals providing services. The LPN/LVN will be supervised by the RN at least monthly."</p> <p>During a record review on 1/2/19 at 1:55 p.m., Patient 1's record indicated a supervisory visit by Employee D (an RN) on 11/2/18, 11/30/18, and 12/28/18. The supervisory visits for the LPN indicated the following: Follows and implements the care plan; Maintains and implements Standard Precaution per agency policy; Prompt, stays required length of time and is reliable; Appears competent in the delivery of service; Performs tasks as requested by the patient within job description; Relates well with the patient/family; Adheres to the dress code; Reports complications and problems to case manager/supervisor; Caring and sympathetic to the patient's needs. The supervisory visits for the LPN indicated: The agency admit folder is readily available; The patient has a continued need for services; The care plan has been updated as required."</p> <p>During an interview on 1/3/19 at 11:25 a.m., Employee G (an LPN - Licensed Practical Nurse) indicated she would see Patient 1 every Monday through Friday for eight hours per day. Employee G indicated no RN visits had conducted in Patient 1's home.</p>		<p>done by the RN. The scheduler will keep a calendar of all supervisory visits that need to be made and will put them on the RN's weekly schedule.</p> <p>The Administrator is responsible for in-servicing the scheduler and the RN's on this.</p>	

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N 0610 Bldg. 00	<p>During an interview on 1/3/19 at 1:59 p.m., Employee D indicated supervisory visits were done by the RN via phone with Patient 1's mother since they were not there during the LPN visits.</p> <p>During an interview on 1/3/19 at 2:34 p.m., Employee D indicated an RN only goes to see Patient 1 if needed.</p> <p>410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.</p> <p>Based on record review and interview, the facility failed to ensure a recertification visit was appropriately signed by the staff member with their name and title for 1 of 7 records reviewed. (Patient 1)</p> <p>Findings include:</p> <p>A policy, revised 2014, and titled, "Nursing Services," was provided by the Administrator on 1/4/19 at 1:30 p.m. The policy indicated, but was not limited to, "Professional nursing services will be provided by a registered nurse and include: Initial and ongoing comprehensive assessments of the patient's needs, including Outcome and Assessment Information Set (OASIS) assessments at appropriate points."</p> <p>During a record review on 1/2/19 at 1:55 p.m., Patient 1's record indicated a recertification visit on 11/8/18 with time in and time out listed as "-NA-" (not applicable). The recertification visit</p>	N 0610	All assessment visit papers will be signed by appropriate staff. The Assistant administrator will review all assessments to ensure proper signatures are in place. The administrator will in-service nursing staff and office staff of the nursing services policy.	01/25/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	note was not signed by any staff member. During an interview on 1/3/19 at 2:32 p.m., the Assistant Administrator indicated all recertification visit notes should be signed by the nurse.				