

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375
--	--

(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
G0000	<p>This visit was for a home health federal recertification survey. This was a partial extended survey.</p> <p>Survey date: December 27-30, 2011</p> <p>Facility #: 004623</p> <p>Medicaid Vendor #: 200957800A</p> <p>Surveyor: Ingrid Miller, PHNS, RN</p> <p>Skilled unduplicated census: 216</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 6, 2012</p>	G0000		
G0158	<p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on document review, observation, and interview, the agency failed to ensure the aide only performed tasks identified on the plan of care for 1 of 2 home health aide visit observations (clinical record #2) with the potential to affect all the aide's</p>	G0158	<p>The Director of Nursing will review with Employee A the home health aide job description, agency policy and procedure and home health aide assignment and also schedule a supervisory visit with employee A this week. Plan of care and home health aide</p>	01/18/2012

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>patients.</p> <p>Findings</p> <p>1. On 12/28/11 at 10:30 AM, Employee A, a home health aide, was observed at a home visit to pour Epsom salts into a warm water foot soak.</p> <p>2. Clinical record #2, start of care (SOC)9/20/11, included a plan of care (POC) for the certification period 11/19/11- 1/17/12 that failed to evidence a medication / treatment order on the POC for Epsom salt warm foot soaks.</p> <p>3. On 12/29/11 at 8:30 AM, the director of nursing indicated the Epsom salt footsoaks were not to be performed by the aide.</p>		<p>assignment will be updated as needed. Skilled nurse assigned for follow-up visits will continue supervisory visits on Employee A no less frequently than every 14 days. The agency will make sure that a registered nurse or qualified therapist (for therapy case only) will complete the home health aide assignment for patient's clinical record and patient's booklet if aide service is indicated upon start of care, recertification or upon physician order. The home health aide assignment will include specific care/tasks to be performed by the aide and also, frequency of visit. The skilled nurse or qualified therapist will follow plan of care regarding order for aide service and supervisory visit no less frequently than every14 days and document the visit. The skilled nurse or qualified therapist, at the time of a follow-up visit will also review and document any new/change in medication /treatments both prescribed by physician and over the counter. Skilled nursing notes was revised and implemented on 01/09/12 to include this review. Any verbal order will be written, signed and dated by the appropriate RN or skilled therapist and countersigned by ordering physician. The written order for the new /change in medication/treatment will be available in patient's clinical record; and when applicable,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375
--	--

(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
G0159	<p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, home visit observation, policy and document review, and interview, the agency failed to ensure current medications and treatments were listed on the plan of care for 3 of 6 home visits observed (Clinical records #3, #4, and #5) with the potential to affect all</p>	G0159	<p>home health aide assignment will be updated. If home health aide assignment is updated, the assigned aide will be provided with a copy. QA staff will continue to review clinical records to make sure that plan of care, verbal orders countersigned by physician and updated home health aide assignment are available in patient's clinical record. QA staff will continue to monitor skilled nurse or qualified therapist's documentations on aide supervisory visits and aide's documentations to ensure compliance with plan of care, physician order and home health aide assignment. All QA staff concerns will be addressed immediately to the Director of Nursing.</p> <p>The Administrator held a post survey staff meeting with the nursing department and office staff on 01/09/12. Agency policies and procedures, CMS and state guidelines on completing a comprehensive assessment and oasis, plan of care and physician orders were discussed. The Administrator approved to revise</p>	01/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the patients of the agency.</p> <p>Findings include</p> <p>1. On 12/28/11 at 9:30 AM at a home visit, patient #3 was observed to be on oxygen 3 liters per nasal cannula continuously. The oxygen use was also listed on the initial assessment. Additionally, the caregiver for patient #3 indicated Tylenol Arthritis tablets for pain were given to the patient twice daily. The caregiver had a medication list of the patient's current medications with Tylenol Arthritis listed.</p> <p>a. A home document titled "[name of Patient #3]'s Medications stated, "9 AM: Tylenol Arthritis [for] pain 2 tablets twice daily and 9 PM Tylenol Arthritis listed as follows: 9 PM: Tylenol Arthritis [for] pain 2 tablets twice daily." This was the current medication list used by the patient's home caregiver for daily medication administration.</p> <p>b. Clinical record #3, SOC 12/1/11, included a plan of care (POC) for the certification period 12/1/11 - 1/29/12 that failed to evidence a medication / treatment order for Tylenol Arthritis tablets and oxygen.</p> <p>c. The initial assessment in patient</p>		<p>the skilled nursing notes to include medication review and to be implemented effective immediately. All skilled nurses not present during the meeting were notified by telephone. The Administrator issued a memorandum on 01/10/12 to all visiting staff which included timely submission of accurate and complete documentations. The Director of Nursing will make sure that all registered nurses/ admitting clinicians at the time of admission will review and document accurate and complete list of patient's medication and treatments both prescribed by physician including respiratory and oxygen treatments and over the counter. The registered nurse will clarify any medication or treatment with ordering physician or pharmacy as needed before submitting documents to agency. The Director of Nursing / designee will establish a written plan of care specific to adequately meet patient's medical, nursing and social needs and will review for accuracy and consistency with clinician's assessment and documentations especially medications and treatments before sending the plan of care to physician for approval. The skilled nurse will be provided with a copy of the plan of care. A physician signed plan of care will be available in patient's clinical record at all times. The skilled nurse, at the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011	
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>#3's record titled "Start of care" with a SOC date of 12/1/11 and completed by Employee E, a Registered Nurse (RN), on 12/1/11 for the initial assessment states, "Respiratory treatments utilized at home: Oxygen @3 lpm [liters per minute] nc [nasal cannula]."</p> <p>d. On 12/29/11 at 1:40 PM, the director of nursing indicated Tylenol Arthritis and oxygen per nasal cannula were not listed on the POC.</p> <p>2. On 12/28/11 at 10:20 AM at a home visit observation, patient #4 and patient #4's caregiver indicated the patient was on oxygen at bedtime at 2 liters per nasal cannula. An oxygen concentrator was present in the home.</p> <p>a. Clinical record #4, SOC 9/9/11, included a POC for the certification period 11/8/11 - 1/6/12 that failed to evidence a medication / treatment order for oxygen at night.</p> <p>b. On 12/29/11 at 2 PM, the director of nursing indicated no oxygen order was present on the POC.</p> <p>3. On 12-29-11 at 10 AM at patient #5's home visit observation, patient #5's home caregiver showed the actual medications the patient was currently taking. One</p>		<p>time of a follow-up visit will also review and document any new/change in medication /treatments both prescribed by physician and over the counter. Skilled nursing notes was revised and implemented on 01/09/12 to include medication review. All skilled nurses and QA staff were educated on the new notes. Any verbal order will be written, signed and dated by the appropriate nurse and countersigned by ordering physician. The written order for medication/treatment will be available in patient's clinical record and medication profile will be updated. Patient's booklet (medication profile section) will be updated by the skilled nurse as well. QA staff will continue to review clinical records to monitor nurse's compliance to revised skilled nursing notes, policy and procedure on verbal orders and updates in medication profile. All QA staff concerns will be addressed immediately to the Director of Nursing.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>medication, allopurinol, was listed on the POC and medication profile, but was not included in the patient's supply. The caregiver indicated allopurinol had been discontinued prior to the SOC.</p> <p>Additionally, a tube of cream states on the prescription label: "Lidocaine - prilocaine cream: apply to affected area three times a week." This cream was ordered three times daily on the POC.</p> <p>b. The POC with a certification period of 12/13/11 - 2/10/12 states, "Allopurinol 100 mg [milligrams] 1 tab [tablet] daily oral and EMLA [brand name for lidocaine - prilocaine] cream three times a day transdermal."</p> <p>c. On 12/29/11 at 2:10 PM, the director of nursing indicated EMLA cream was listed as three times a day rather than three times a week and a discontinued medication, allopurinol were listed on the POC.</p> <p>4. The agency policy titled "Medication Reconciliation" with no revision date states "Agency will reconcile all medications taken by the client prior to admission, before and after inpatient admission stays, and at the time of discharge ... Special instructions 1. At the time of admission to the home care agency, the admitting professional will</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>document a complete list of medications taken by the client prior to admission. This will include all over the counter, prescribed, and PRN [as needed] medications. Documentation of these medications will be listed on the Medication Profile and include name, dose, route of administration, frequency and when last dose was taken. 2. The information will be obtained from the client if possible. If the client is unable to communicate this information, it may be obtained from family members, medication bottle labels, client's pharmacy or from an inpatient facility if recently discharged. 3. The admission professional will review this medication list with the physician and confirm these medications are to be continued or discontinued ... "</p> <p>5. The agency policy titled "Medication Management" with no revision date states, "Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking ... and records this in the patient record ... Medications in the home are reviewed with the patient/family to determine current medications and patient understanding of the medication actions and side effects. Medications in the home that are not on the current plan of care</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>will be checked to assure they have not expired, and to review if medications are being prescribed by multiple physicians ... Medication orders 1. Written orders must be legible and clearly documented. A complete medication order includes the full name of the drug, dose and time drug is to be administered ..."</p> <p>6. The agency policy titled "II Patient Care" with an effective date and revision date of 2/25/10 states, "The nurse develops a plan of care consistent with client/family needs and then confers with the physician regarding the needed services and frequency of visits based on the home environment and the client's condition. The Medicare Form 485 is generated from the physician and nurse's collaborative efforts. This form functions as both the plan of care and letter medical necessity. Each patient's plan of care will include (as appropriate) a description of medication and need for home health care, the results of the assessment ... long and short-term goals of treatment and expected outcomes."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
G0224	<p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on home visit observation, staff interview, and clinical record and policy review, the agency failed to ensure the home health aide had written patient care instruction for 1 of 4 home observations with home health aide services (Clinical record #4).</p> <p>Findings</p> <ol style="list-style-type: none"> 1. On 12/28/11 at 10:20 AM, Patient #4's home record evidenced no written patient care instructions for the home health aide. 2. Clinical record #4, SOC 9/9/11, included a plan of care for the certification period 11/8/11 - 1/6/12 with orders for aide services twice a week. 3. On 12/29/11 at 1:45 PM, the director of nursing indicated there were no written instructions for the home health aide in the patient's home. 	G0224	<p>The Director of Nursing will make sure that written patient care instructions for the aide will be prepared by the RN if patient receives skilled nursing care or by the qualified therapist if patient receives only therapy. The Director of Nursing met with RN who completed the oasis and comprehensive assessment on patient # 4, and instructed RN to always complete the home health aide assignment not only for patient's office record, but also for the patient's home record and for the aide . A copy of the aide assignment was provided for patient # 4's home record. The Administrator issued a memorandum on 1/10/12 to all visiting staff regarding submission of complete documentations which included: oasis with comprehensive assessments and home health aide assignment if ordered. The Administrator met with the clerk in-charge of preparing the admission and recertification packets to include aide assignment sheets for each certification. All home health</p>	01/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(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	
G0229	<p>4. The agency policy titled "Home Health Aide" with an effective date of 2/25/10 states, "Job Description - Home health aide, Home health aide services shall be under the supervision of a registered nurse in accordance with the plan of treatment. The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or the appropriate therapist."</p> <p>5. The agency policy titled "Home Health Aide Services" with no effective date states, "Written instructions for the homemaker-home health aide shall be completed before the homemaker - home health aide provides any service to the patient."</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse made on-site visits to the patient's home no less frequently than every 2 weeks for 3 of 8</p>	G0229	<p>aides, nurses and qualified therapist were instructed to review patient's record at home during each visit and to notify office if aide assignment for the certification if ordered, is completed and present on patient's record. The Director of Nursing with the coordination of QA staff will continue to review all clinical records for its completion; to make sure that the home health aide assignment is available, updated and is according to the plan of care. The staffing coordinator will be in-charge of providing the home health aide with a copy of the written assignment prepared by the registered nurse/ qualified therapist as needed. All staff concerns will be addressed immediately to the Director of Nursing.</p> <p>On 01/10/12, the Director of Nursing had a conference with all skilled nurses to review agency policies/procedures and state guidelines on aide supervisory visits and importance of proper documentation for that visit.</p>	01/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>clinical records reviewed of patients with skilled and home health aide services (clinical record #4, #8, and #12.)</p> <p>Findings include</p> <p>1. Clinical record #4 included a plan of care for the certification periods 9/9/11 -11/7/11 and 11/8/11 - 1/6/12 with orders for home health aide services two times a week for 9 weeks. The record failed to evidence supervisory visits from 10/15/11 through 11/11/11.</p> <p>2. Clinical record #8 included a plan of care for the certification period 10/1/11 - 11/29/11 with orders for home health aide services two times a week for 9 weeks. The record failed to evidence any supervisory visits in this certification period.</p> <p>3. Clinical record #12 included a plan of care for the certification period 9/21/11 - 11/19/11 with orders for home health aide services 6 hours a day for 26 weeks. The record failed to evidence any supervisory visits had been made in this certification period.</p> <p>4. The agency policy titled "Supervision of staff" states, "All staff providing home care services will be supervised as outlined by federal and state regulations</p>		<p>Skilled nurse (if patient receives skilled nursing) or qualified therapist (if patient receives therapy only) will conduct aide supervisory visit no less frequently than every 14 days and document in visit notes. The Director of Nursing will include a schedule of aide supervisory visit on the patient visit schedule when establishing the plan of care. Skilled nurse or qualified therapist assigned to patient will have a copy of this patient visit calendar and plan of care. The Administrator will revise the Progress Sheet form on patient's booklet to include a column for aide supervisory visits. All skilled nurses or other appropriate professional will be educated on the new Progress Sheet prior to its implementation date which is 01/23/12. QA staff will continue to monitor skilled nurse or other appropriate professional's documentations on aide supervisory visits and aide's documentations to ensure compliance with plan of care, physician order and home health aide assignment. All QA staff concerns will be addressed immediately to the Director of Nursing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
G0337	<p>and accepted standards of practice."</p> <p>5. On 12/30/11 at 2:15 PM, the director of nursing indicated no supervisory visits were evidenced in these clinical records.</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review, home visit observation, policy and document review, and interview, the agency failed to ensure the medication profile was accurate for 2 of 12 records reviewed (Clinical records #3 and #5).</p> <p>Findings include</p> <p>1. On 12/28/11 at 9:30 AM at a home visit, patient #3's caregiver indicated patient #3's Tylenol Arthritis tablets for pain were given to the patient twice daily. The caregiver had a medication list of the patient's current medications with Tylenol Arthritis listed. This medication failed to be listed on the medication profile.</p> <p>a. A home document titled "Patient</p>	G0337	<p>On 01/09/12, the Administrator held a post survey staff meeting with the nursing department and office staff. Agency policies/procedures, CMS and state guidelines on completing a comprehensive assessment and oasis, plan of care and physician orders on medication/treatments were discussed. The Administrator issued a memorandum on 01/10/12 to all visiting staff which included timely submission of accurate and complete documentations. The Administrator approved to revise the skilled nursing notes to include medication review to be implemented effective immediately. All skilled nurses not present during the meeting were notified about the new form. The Director of Nursing will make sure that all registered nurses/ admitting clinicians at the time of admission will review and document accurate and complete</p>	01/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#3's Medications stated, "9 AM: Tylenol Arthritis [for] pain 2 tablets twice daily and 9 PM Tylenol Arthritis listed as follows: 9 PM: Tylenol Arthritis [for] pain 2 tablets twice daily." This was the current medication list used by the patient's home caregiver for daily medication administration.</p> <p>b. Clinical record #3, start of care (SOC) 12/1/11, evidenced a medication profile signed by Employee E on 12/1/11 which did not include Tylenol Arthritis tablets.</p> <p>c. On 12/29/11 at 1:40 PM, the director of nursing indicated Tylenol Arthritis tablets were not included on the medication profile.</p> <p>2. On 12-29-11 at 10 AM at patient #5 home visit observation, patient #5's home caregiver showed the actual medications the patient was currently taking. One medication, allopurinol, was listed on the plan of care and medication profile, but was not included in the patient's home supply of medications. The caregiver indicated allopurinol had been discontinued prior to the SOC. Additionally, a tube of cream with the statement on the prescription label: "Lidocaine - prilocaine cream: apply to affected area three times a week." This</p>		<p>list of patient's medication and treatments both prescribed by physician including respiratory and oxygen treatments and over the counter. The registered nurse will clarify list of medication or treatment with ordering physician or pharmacy as needed before submitting documents to agency. The Director of Nursing / designee will establish a written plan of care specific to adequately meet patient's medical, nursing and social needs and will review its accuracy and consistency with clinician's assessment and documentations especially medications and treatments before sending the plan of care to physician for approval. The skilled nurse will be provided with a copy of the plan of care. A physician signed plan of care will be available in patient's clinical record at all times. The skilled nurse, at the time of follow-up visit will also review and document any new/change in medication /treatments both prescribed by physician and over the counter. Skilled nursing note was revised and implemented on 01/09/12 to include medication review. All skilled nurses and QA staff were educated on the new notes. Any verbal order will be written, signed and dated by the appropriate nurse and countersigned by ordering physician. The written order for medication/treatment will be available in patient's</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>cream was listed on the medication profile as follows: "EMLA Cream apply transdermal tid [three times a day] affected area.</p> <p>a. Clinical record #5, SOC 12/13/11, evidenced a medication profile signed by Employee E on 12/15/11 which states, "EMLA cream apply transdermal tid [three times a day] affected area and Allopurinol 100 mg [milligrams] po [by mouth] daily. This medication profile did not reconcile with the patient's medication supply.</p> <p>c. On 12/29/11 at 2:10 PM, the director of nursing indicated EMLA cream was listed as three times a day rather than three times a week and a discontinued medication, allopurinol, were listed on the medication profile incorrectly.</p> <p>3. The agency policy titled "Medication Reconciliation" states "Agency will reconcile all medications taken by the client prior to admission, before and after inpatient admission stays, and at the time of discharge ... Special instructions 1. At the time of admission to the home care agency, the admitting professional will document a complete list of medications taken by the client prior to admission. This will include all over the counter,</p>		<p>clinical record and medication profile will be updated . The medication profile section on patient's booklet will be updated by skilled nurse. QA staff will continue to review clinical records to monitor nurse's compliance to revised skilled nursing notes and accuracy of verbal orders and medication profile. All QA staff concerns will be addressed immediately to the Director of Nursing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375
--	--

(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
N0522	<p>prescribed, and PRN [as needed] medications. Documentation of these medications will be listed on the Medication Profile and include name, dose, route of administration, frequency and when last dose was taken. 2. The information will be obtained from the client if possible. If the client is unable to communicate this information, it may be obtained from family members, medication bottle labels, client's pharmacy or from an inpatient facility if recently discharged. 3. The admission professional will review this medication list with the physician and confirm these medications are to be continued or discontinued ... "</p> <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 document review, observation, and interview, the agency failed to ensure the aide only performed tasks identified on the plan of care for 1 of 2 home health aide visit observations (clinical record #2).</p> <p>Findings</p> <p>1. On 12/28/11 at 10:30 AM, Employee</p>	N0522	The Director of Nursing will review with Employee A the home health aide job description, agency policy and procedure and home health aide assignment and also schedule a supervisory visit with employee A this week. Plan of care and home health aide assignment will be updated as needed. Skilled nurse assigned for follow-up visits will continue supervisory visits on Employee A	01/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>A, a home health aide, was observed at a home visit to pour Epsom salts into a warm water foot soak.</p> <p>2. Clinical record #2, start of care (SOC)9/20/11, included a plan of care (POC) for the certification period 11/19/11- 1/17/12 that failed to evidence a medication / treatment order on the POC for Epsom salt warm foot soaks.</p> <p>3. On 12/29/11 at 8:30 AM, the director of nursing indicated the Epsom salt footsoaks were not to be performed by the aide.</p>		<p>no less frequently than every 14 days. The agency will make sure that a registered nurse or qualified therapist (for therapy case only) will complete the home health aide assignment for patient's clinical record and patient's booklet if aide service is indicated upon start of care, recertification, resumption of care or physician order. The home health aide assignment will include specific care/tasks to be performed by the aide and also, frequency of visit. The skilled nurse or qualified therapist will follow the plan of care regarding order for aide service and supervisory visit to occur no less frequently than every14 days and document the visit. The skilled nurse or qualified therapist, at the time of follow-up visit will also review and document any new/change in medication /treatments both prescribed by physician and over the counter. Skilled nursing notes was revised and implemented on 01/09/12 to include this review. Any verbal order will be written, signed and dated by the appropriate RN or skilled therapist and countersigned by ordering physician. The written order for the new /change in medication/treatment will be available in patient's clinical record; and when applicable, home health aide assignment will be updated. If home health aide assignment is updated, the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			assigned aide will be provided with a copy. QA staff will continue to review patient's clinical records to make sure that plan of care, verbal orders countersigned by physician and updated home health aide assignment are available in patient's clinical record. QA staff will continue to monitor skilled nurse or qualified therapist's documentations on aide supervisory visits and aide's documentations to ensure compliance with plan of care, physician order and home health aide assignment. All QA staff concerns will be addressed immediately to the Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(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	
N0524	<p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record review, home visit observation, policy and document review, and interview, the agency failed to ensure current medications and treatments were listed on the plan of care for 3 of 6 home visits observed (Clinical records #3, #4, and #5) with the potential to affect all the patients of the agency.</p> <p>Findings include</p> <p>1. On 12/28/11 at 9:30 AM at a home</p>	N0524	The Administrator held a post survey staff meeting with the nursing department and office staff on 01/09/12. Agency policies and procedures, CMS and state guidelines on completing a comprehensive assessment and oasis, medications and treatments, plan of care and physician orders were reviewed and discussed. The Administrator approved to revise the skilled nursing notes to include medication review to be implemented effective immediately. All skilled nurses not present during the meeting were	01/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>visit, patient #3 was observed to be on oxygen 3 liters per nasal cannula continuously. The oxygen use was also listed on the initial assessment. Additionally, the caregiver for patient #3 indicated Tylenol Arthritis tablets for pain were given to the patient twice daily. The caregiver had a medication list of the patient's current medications with Tylenol Arthritis listed.</p> <p>a. A home document titled "[name of Patient #3]'s Medications stated, "9 AM: Tylenol Arthritis [for] pain 2 tablets twice daily and 9 PM Tylenol Arthritis listed as follows: 9 PM: Tylenol Arthritis [for] pain 2 tablets twice daily." This was the current medication list used by the patient's home caregiver for daily medication administration.</p> <p>b. Clinical record #3, SOC 12/1/11, included a plan of care (POC) for the certification period 12/1/11 - 1/29/12 that failed to evidence a medication / treatment order for Tylenol Arthritis tablets and oxygen.</p> <p>c. The initial assessment in patient #3's record titled "Start of care" with a SOC date of 12/1/11 and completed by Employee E, a Registered Nurse (RN), on 12/1/11 for the initial assessment states, "Respiratory treatments utilized at home:</p>		<p>notified by telephone. The Administrator issued a memorandum on 01/10/12 to all visiting staff which included timely submission of accurate and complete documentations. The Director of Nursing will make sure that all registered nurses/ admitting clinicians at the time of admission will review and document accurate and complete list of patient's medication and treatments both prescribed by physician including respiratory and oxygen treatments and over the counter. The registered nurse will clarify any medication or treatment with ordering physician or pharmacy as needed before submitting documents to agency. The Director of Nursing / designee will establish a written plan of care specific to adequately meet patient's medical, nursing and social needs and will review for accuracy and consistency with clinician's assessment and documentations especially medications and treatments before sending the plan of care to physician for approval. The skilled nurse will be provided with a copy of the plan of care. A physician signed plan of care will be available in patient's clinical record at all times. The skilled nurse, at the time of a follow-up visit will also review and document any new/change in medication /treatments both prescribed by physician and over the counter.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011	
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Oxygen @3 lpm [liters per minute] nc [nasal cannula]."</p> <p>d. On 12/29/11 at 1:40 PM, the director of nursing indicated Tylenol Arthritis and oxygen per nasal cannula were not listed on the POC.</p> <p>2. On 12/28/11 at 10:20 AM at a home visit observation, patient #4 and patient #4's caregiver indicated the patient was on oxygen at bedtime at 2 liters per nasal cannula. An oxygen concentrator was present in the home.</p> <p>a. Clinical record #4, SOC 9/9/11, included a POC for the certification period 11/8/11 - 1/6/12 that failed to evidence a medication / treatment order for oxygen at night.</p> <p>b. On 12/29/11 at 2 PM, the director of nursing indicated no oxygen order was present on the POC.</p> <p>3. On 12-29-11 at 10 AM at patient #5's home visit observation, patient #5's home caregiver showed the actual medications the patient was currently taking. One medication, allopurinol, was listed on the POC and medication profile, but was not included in the patient's supply. The caregiver indicated allopurinol had been discontinued prior to the SOC.</p>		<p>Skilled nursing notes was revised and implemented on 01/09/12 to include this review. All skilled nurses and QA staff were educated on the new notes. Any verbal order will be written, signed and dated by the appropriate nurse and countersigned by ordering physician. The written order for medication/treatment will be available in patient's clinical record and medication profile will be updated. The patient's booklet (medication profile section) will be updated by the skilled nurse as well. QA staff will continue to review clinical records to monitor nurse's compliance to revised skilled nursing notes, accurate verbal orders and updated medication profile. All QA staff concerns will be addressed immediately to the Director of Nursing.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Additionally, a tube of cream states on the prescription label: "Lidocaine - prilocaine cream: apply to affected area three times a week." This cream was ordered three times daily on the POC.</p> <p>b. The POC with a certification period of 12/13/11 - 2/10/12 states, "Allopurinol 100 mg [milligrams] 1 tab [tablet] daily oral and EMLA [brand name for lidocaine - prilocaine] cream three times a day transdermal."</p> <p>c. On 12/29/11 at 2:10 PM, the director of nursing indicated EMLA cream was listed as three times a day rather than three times a week and a discontinued medication, allopurinol were listed on the POC.</p> <p>4. The agency policy titled "Medication Reconciliation" with no revision date states "Agency will reconcile all medications taken by the client prior to admission, before and after inpatient admission stays, and at the time of discharge ... Special instructions 1. At the time of admission to the home care agency, the admitting professional will document a complete list of medications taken by the client prior to admission. This will include all over the counter, prescribed, and PRN [as needed] medications. Documentation of these</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>medications will be listed on the Medication Profile and include name, dose, route of administration, frequency and when last dose was taken. 2. The information will be obtained from the client if possible. If the client is unable to communicate this information, it may be obtained from family members, medication bottle labels, client's pharmacy or from an inpatient facility if recently discharged. 3. The admission professional will review this medication list with the physician and confirm these medications are to be continued or discontinued ... "</p> <p>5. The agency policy titled "Medication Management" with no revision date states, "Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking ... and records this in the patient record ... Medications in the home are reviewed with the patient/family to determine current medications and patient understanding of the medication actions and side effects. Medications in the home that are not on the current plan of care will be checked to assure they have not expired, and to review if medications are being prescribed by multiple physicians ... Medication orders 1. Written orders must be legible and clearly documented. A</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011	
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
N0550	<p>complete medication order includes the full name of the drug, dose and time drug is to be administered ..."</p> <p>6. The agency policy titled "II Patient Care" with an effective date and revision date of 2/25/10 states, "The nurse develops a plan of care consistent with client/family needs and then confers with the physician regarding the needed services and frequency of visits based on the home environment and the client's condition. The Medicare Form 485 is generated from the physician and nurse's collaborative efforts. This form functions as both the plan of care and letter medical necessity. Each patient's plan of care will include (as appropriate) a description of medication and need for home health care, the results of the assessment ... long and short-term goals of treatment and expected outcomes."</p> <p>Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on home visit observation, staff interview, and clinical record and policy review, the agency failed to ensure the registered nurse provided written patient</p>	N0550	The Director of Nursing will make sure that written patient care instructions for the aide will be prepared by the RN if patient receives skilled nursing care or by the qualified therapist if patient	01/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>care instructions for the home health aide for 1 of 4 home observations with home health aide services (Clinical record #4).</p> <p>Findings</p> <ol style="list-style-type: none"> 1. On 12/28/11 at 10:20 AM, Patient #4's home record evidenced no written patient care instructions for the home health aide. 2. Clinical record #4, SOC 9/9/11, included a plan of care for the certification period 11/8/11 - 1/6/12 with orders for aide services twice a week. 3. On 12/29/11 at 1:45 PM, the director of nursing indicated there were no written instructions for the home health aide in the patient's home. 4. The agency policy titled "Home Health Aide" with an effective date of 2/25/10 states, "Job Description - Home health aide, Home health aide services shall be under the supervision of a registered nurse in accordance with the plan of treatment. The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or the appropriate therapist." 5. The agency policy titled "Home Health Aide Services" with no effective date 		<p>receives only therapy. The Director of Nursing met with RN who completed the oasis and comprehensive assessment on patient # 4, and instructed RN to always complete the home health aide assignment not only for patient's office record, but also for the patient's home record and for the aide . A copy of the aide assignment was provided for patient # 4's home record. The Administrator issued a memorandum on 1/10/12 to all visiting staff regarding submission of complete documentations which included: oasis with comprehensive assessments and home health aide assignment if ordered. The Administrator met with the clerk in-charge of preparing the admission and recertification packets to include aide assignment sheets for each certification. All home health aides, nurses and qualified therapist were instructed to review patient's record at home during each visit and to notify office if aide assignment for the certification if ordered, is completed and present on patient's record. The Director of Nursing with the coordination of QA staff will continue to review all clinical records for its completion; to make sure that the home health aide assignment is available, updated and is according to the plan of care. The staffing coordinator will be in-charge of providing the home</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(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	
N0606	<p>states, "Written instructions for the homemaker-home health aide shall be completed before the homemaker - home health aide provides any service to the patient."</p> <p>Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the registered nurse made on-site visits to the patient's home no less frequently than every 2 weeks for 3 of 8 clinical records reviewed of patients with skilled and home health aide services (clinical record #4, #8, and #12.)</p> <p>Findings include</p> <p>1. Clinical record #4 included a plan of care for the certification periods 9/9/11 -11/7/11 and 11/8/11 - 1/6/12 with orders for home health aide services two times a week for 9 weeks. The record failed to evidence supervisory visits from 10/15/11 through 11/11/11.</p> <p>2. Clinical record #8 included a plan of</p>	N0606	<p>health aide with a copy of the written assignment prepared by the registered nurse/ qualified therapist as needed. All staff concerns will be addressed immediately to the Director of Nursing.</p> <p>On 01/10/12, the Director of Nursing had a conference with all skilled nurses to review agency policies/procedures and state guidelines on aide supervisory visits and importance of proper documentation for that visit. Skilled nurse (if patient receives skilled nursing) or qualified therapist (if patient receives therapy only) will conduct aide supervisory visit no less frequently than every 14 days and document in visit notes. The Director of Nursing will include a schedule of aide supervisory visit on the patient visit schedule when establishing the plan of care. Skilled nurse or qualified therapist assigned to patient will have a copy of this patient visit calendar and plan of care. The Administrator will revise Progress Sheet form on patient's booklet to include a column for aide</p>	01/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157575	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER QUALITY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CEDAR PKWY SCHERERVILLE, IN46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>care for the certification period 10/1/11 - 11/29/11 with orders for home health aide services two times a week for 9 weeks. The record failed to evidence any supervisory visits in this certification period.</p> <p>3. Clinical record #12 included a plan of care for the certification period 9/21/11 - 11/19/11 with orders for home health aide services 6 hours a day for 26 weeks. The record failed to evidence any supervisory visits had been made in this certification period.</p> <p>4. The agency policy titled "Supervision of staff" states, "All staff providing home care services will be supervised as outlined by federal and state regulations and accepted standards of practice."</p> <p>5. On 12/30/11 at 2:15 PM, the director of nursing indicated no supervisory visits were evidenced in these clinical records.</p>		<p>supervisory visits. All skilled nurses or other appropriate professional will be educated on the new Progress Sheet prior to its implementation date which is 01/23/12. QA staff will continue to monitor skilled nurse or other appropriate professional's documentations on aide supervisory visits and aide's documentations to ensure compliance with the plan of care, physician order and home health aide assignment. All QA staff concerns will be addressed immediately to the Director of Nursing.</p>		